BAKER, HEARD, OSTEEN, DAVENPORT, M.D., P.A.
PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize BAKER, HEARD, OSTEEN, DAVENPORT, P.A. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits BAKER, HEARD, OSTEEN, DAVENPORT, M.D., P.A. to use or disclose to the following individually identifiable health information (specifically - describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).
_____
_____
_____

NOTE: PATIENT OR REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:
To release all Psychiatric/psychological information* _____ (Initials)
Alcohol and/or drug/chemical information* _____ (Initials)
HIV tests and information pertaining to these tests or to treatment in connection with these tests* _____ (Initials)
***if the patient is under the age of 17 years, the parent or legal guardian of the patient must sign for the release of this information.**

TO RELEASE RECORDS TO:
(Name of Facility/persons to receive this information) _____

(Address of above facility and/or persons) _____

City, State, ZIP _____

This authorization will expire on _____.
(Expiration Date or Defined Event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that BAKER, HEARD, OSTEEN, DAVENPORT, M.D., P.A. has acted in reliance upon this authorization. My written revocation must be submitted to BAKER, HEARD, OSTEEN, DAVENPORT, M.D., P.A.'S Privacy Officer at 345 West Michigan St., Suite #114, Orlando, FL 32806

_____	_____	_____
Patient/Client/Legal Representative Signature	Relationship to Patient/Client	Date
_____	_____	_____
Witness Signature	Title/Position	Date