

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_, hereby authorize  
(Name of Patient)

\_\_\_\_\_  
(Name of Physician, Hospital, Facility, etc.)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone #)

\_\_\_\_\_  
(Fax #)

To release: medical; psychiatric; drug and/or alcohol abuse; HIV testing or AIDS information; or specifically \_\_\_\_\_ in my records to:  
Emmanuel Christian Health Center (Vivian Woodard, M.D. & Leonie Morgan, A.R.N.P.)  
For the purpose of: continuing medical care.

I understand that this consent is revocable upon written notice to the facility, except to the extent that action by the facility has been taken in reliance on this authorization shall remain in force for a reasonable time in order to affect the purpose for which it is given, but no longer than six months.

Federal Law if present has been disclosed from records whose confidentiality protects alcohol/drug abuse information. Federal regulations (42CFR part II) prohibit making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations, mental behavior, HIV testing, and/or AIDS related diagnosis is further prohibited from further disclosure by State Regulations without the specific written consent from the patient.

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Patient Signature in Full

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent, Legal Guardian, or Authorized Representative Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness Signature

**Please Mail or Fax Records to:**

918 Rolling Acres Rd, Ste 1  
Lady Lake, FL 32159  
Tel: (352) 259-1991  
Fax: (352) 259-5540

885 N Powers Dr, Ste D  
Orlando, FL 34711  
Tel: (407) 522-1925  
Fax: (407) 522-1865