Elias H Sarkis, MD
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Phone (352) 331-5100 Fax (352)332-9607

AUTHORIZATION TO RELEASE INFORMATION

I voluntarily authorize SARKIS FAMILY PSYCHIATRY to:

_____ Release to:
_____ Obtain from: _____
Name of person, facility

_____
City, State, Phone, Fax

Written and/or verbal information from the record of:

_____
Patient

_____
Date of Birth

This information is to be used for the purpose of:
_____ My follow up care
_____ Other (specify) _____

Specific information to be released:
_____ All records
_____ History/Physical Examination/Admission/Discharge Summary
_____ Lab reports, EKG, Operative Reports
_____ Psychiatric/ Psychological Consults
_____ Other (specify) _____

1. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____**Initial**
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorized the disclosure health information as stated.

Signature of patient: _____ Date: _____

Signature of Parent/Guardian: _____ Relationship: _____

Witness: _____ Date: _____

This release will be valid for: ☐ Single Disclosure ☐ Continuing for 1 year from signature date above

PLEASE FAX RECORDS TO OUR SECURE FAX NUMBER (352) 332-9607