AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION

Patient Name:_____

Date of Birth: _____

Telephone Number: _____

Address: _____

REQUESTED FROM

Name of Facility:_____

Address:_____

_____

Telephone Number: _____

Fax Number: _____

Date(s) of Service Requested: _____

Reason for Disclosure: Continuation of Care

Mail Information to:

Dr. Katina Health and Wellness, Inc.
2901 Coral Hills Drive #330
Coral Springs, Florida 33065
Fax: 954-231-8707
Email: Info@DrKatinaHealth.com

INFORMATION TO BE RELEASED

Complete Medical Record:_____ Operative Reports_____

Pathology Reports: _____ Radiology Reports: _____

Lab Reports: _____ Other (please specify) _____

The following will not be released unless you specifically authorize it by marking the relevant box(es) below:

Drug/Alcohol Abuse or Treatment: _____ Genetic Testing Information: _____

HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses: _____

Mental Health Treatment or Psychotherapy Notes_____

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your healthcare (or payment for care) will not be affected by whether or not you sign this authorization. Once your healthcare information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

Patient Signature: _____

Date Signed: _____

Print Name:

_____

Relationship, if Other than the Patient:

_____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e., court appointed guardian, Durable Power of Attorney for Health Care).

**For a deceased patient: A death certificate coupled with Executor or Administrator of Estate paperwork must accompany authorization; or a court entry or order appointing a Fiduciary, Executor, or Administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the Administrator or Executor of the estate.

****Exception: Parent signing for patient under the age of 18.