Date of Birth: ___________________
Social Security Number:___________________

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Pursuant to Federal Regulation 42cfr, Part 2 ; Florida Statutes Chapters 381, 394-397 and/or 445, I authorize the release of my : Medical, psychiatric, psychological, alcohol and/or substance abuse treatment records, information about Sexually Transmitted Diseases including HIV Tests & Related Information and/or any other information considered sensitive information.

Please : ☐ *Mail copies to:* ☐ *Fax copies to:* ☐ *Hold for pickup:*

☐ **Garcia & Giron MD PA**
3661 South Miami Avenue
Suite 702
Miami, FL, 33133
Fax: (305) 857-3338

OR

☐ Name/Facility: ______________________________ Attention: ___________________
Address: ___________________________________ Phone: ______________________
City: _______ State: ________ Zip: ______ Fax: ________________________

Purpose of request: ☐ Personal ☐ Continuing Care (PCP or refer to specialist) ☐ Insurance ☐ Legal ☐ Change of treating doctor ☐ Other __________

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person(s) or agency. I also understand that I may revoke this release of information at any time provided that I notify the facility and/or physician in writing to this effect, but that revocation has no effect on action taken previously. This authorization shall remain in force until such time that the purpose for which it was given is accomplished or until one year from the time it is dated has passed.

__________________________________ ________________
Signature of Patient/Client/Guardian Date

____
Name of Patient/Client

GARCIA & GIRON MD PA
Diplomat of American Board of Internal Medicine and Infectious Diseases
3661 S. Miami Ave # 702, Miami, FL 33133 • TEL. 305.857.3330 • Fax: 305.857.3338