

V. L. Dawson, Jr MD



515 W. St. Rd. 434
Suite 301
Longwood, FL 32750

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any physician, hospital, clinic, pharmacy, insurance company, or other healthcare provider to release any medical, psychiatric, drug use, alcohol abuse, HIV testing, ARC, or AIDS information* in the records of the patient named below, to:

Longwood Family Medicine, P.A.
515 W. St. Rd. 434, Suite 301
Longwood, FL 32750

for the purpose of medical care.

I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years in order to effect the purpose for which it is given.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation 42 CFR part II prohibits making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, ARC, and or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

A photocopy of this authorization shall be considered as valid as the original.

Patient's name

Patient's date of birth

Date of authorization

Signature of patient, parent,
or legal guardian

Relationship to patient

*Any of the categories above may be deleted by marking through them.

V. L. Dawson, Jr MD



515 W. St. Rd. 434
Suite 301
Longwood, FL 32750

AUTHORIZATION TO DISCUSS MEDICAL CARE
WITH FAMILY MEMBERS AND/OR OTHER INDIVIDUALS

Patient's Name: _____ Date of Birth: _____

I hereby authorize the physicians and staff members of Longwood Family Medicine to discuss the medical care of the patient named above with the people listed below. This may include, but is not limited to, releasing information related to psychiatric care, drug use, alcohol abuse, HIV testing, ARC and AIDS.

I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years unless revoked.

Name:

Relationship:

Signature of patient, parent, or legal guardian:

Date of authorization:

Relationship to patient:
