TRINITY MEDICAL GROUP

LAKELAND
3240 South Florida Avenue
Suite 101 :: FL 333803
Ph: 863.646.4000 :: F: 863.644.2857

# AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT NAME _____ PHONE # _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S ADDRESS _____

PREVIOUS DOCTOR _____

## PLEASE INDICATE

(PLEASE SIGN AND DATE BELOW)

**INFORMATION AUTHORIZED FOR USE OR DISCLOSURE, OR TO BE OBTAINED:** (PLEASE CHECK ALL THAT APPLY)

- ❍ All medical information concerning patient listed above
- ❍ Medical information of this patient compiled between _____ to _____
- ❍ Only: _____ Hospital Records _____ E.R. Records at _____

Dates of treatment is known: _____

**THIS INFORMATION WILL BE OBTAINED, USED, OR DISCLOSED FOR THE FOLLOWING PURPOSE(S) ONLY:**

- ❍ Insurance
- ❍ Continuity of care
- ❍ Legal
- ❍ At the request of the patient or the patient's representative.
- ❍ Other (Please specify): _____

I hereby authorize Trinity Medical Group to release and obtain any medical and other pertinent information to and from ALL health care practitioners, providers, agencies, schools, hospitals, and institutions for the purpose of the client's diagnosis care and treatment.

I may revoke this authorization at any time, IN WRITING, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to the office of Trinity Medica Group by certified mail.

PRINT PATIENT'S NAME/ LEGAL REP _____ DATE SIGNED _____ EXP. DATE _____

PATIENT SIGNATURE/ LEGAL REP _____ RELATIONSHIP TO PATIENT _____