Triana Prevention Center
3155 Harbor Blvd., Ste. 100
Port Charlotte, FL 33952
941-625-1990 FAX 941-625-1991

As required by the Accountability Act of 1996 (HIPAA), this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice, _____
(name of practice/doctor)
to release health information of _____
(print patient name)
Date of birth:_____ Soc. Sec. #_____

Other names, maiden name:_____

Information to Release: Consult from date of service_____

OR ____Entire Medical Record ____Lab Reports ____ Mammogram

____ X-Ray Report of _____

____Other_____

Reason for Release: _____
Send Medical Records to:
Name: _____
Address: _____
_____
Phone: _____

Restrictions: I understand that the recipient of this form may not use or disclose this information except for the expressed Purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that the information in my health record may include information relating to sexually transmitted disease, required immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusions: (please initial) Drug/Alcohol_____, Mental Health/Psychiatric_____, HIV/AIDS_____, Sexually Transmitted Disease_____, Other_____, description of other_____

This authorization is effective this date: _____through_____

Signature:_____Print Name_____

I am the ___Patient___Guardian___Conservator___Patient's Representative **Date_____**