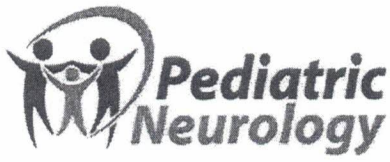

AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

I (Parent/Guardian Name) _____, hereby authorize

Institute of Pediatric Neurosciences of Florida PLLC
1315 SE 25 Loop, Suite 104. Ocala, FL 34471
Phone: (352) 512-9898 Fax: (855) 889-8577

To release, receive, and/or discuss the following information:

_____ Complete Medical Records
_____ Labs/Diagnostic Testing
_____ Mental Health Treatment (if applicable)
_____ Other _____

PLEASE PRINT NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN AND/OR FACILITY BELOW
(One form per facility):

_____

_____

_____

Signature: _____ **Date:** _____

Relationship to Patient: _____

I have carefully read and understand the above information and do herein consent to its disclosure. I am aware that information regarding any medical condition(s) will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

- I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.
- I authorize the use of a copy of this form for the disclosure of the information described above.
- I understand this authorization will remain in effect for one year from the date of my signature below unless I have specified a different expiration date. *(Please list desired expiration date of release here:_____)*