Authorization for Release of Medical Information

Regarding:

_____

(Print Patient's Name)

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any re-disclosure is strictly prohibited without written permission of the patient/client/legal representative identified below.

I authorize:

Beth Hershkowitz Hall, Ph.D.
6499 Powerline Road, Suite 209
Fort Lauderdale, FL 33309
Phone# : (954) 772-6677
Fax# : (954) 772-6711

to release written general medical information form my medical records as well as psychiatric/psychological information, alcohol and/or drug abuse information, Human Immunodeficiency Virsus (HIV) tests and other important information pertaining to these tests or to treatment in connection with these results to:

_____

(Name of facility/person to receive information)

_____

(Address)

_____

(City, State, Zip code)

for the purpose of: _____

_____ _____

Patient's/Legal Representative's Signature Date Date of Birth

_____

Print Name

_____

Signature of Witness Date

_____

Legal Representative's Relationship to patient

_____ _____

Date Mailed / Faxed Signature of Staff Representative

NOTE TO PATIENT: Effective Friday, January 16, 2009 a fee of $1.00 per page for the first 25 pages, and $0.25 for each additional page will be charged for all medical records sent, other then those sent directly to another physician's office for the use of patient evaluation. An additional fee of $3.00 will be charged for medical records that are mailed within the United States, additional fees for international mail will apply.
This fee is in compliance with Florida Law – 64B8-10.003