**7000 SW 62 Avenue, Suite 350**
**South Miami, Fl. 33143**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____________________________________

Social Security: _________-_________-_________ Date of Birth: ______/______/_______

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**Please select all that apply:**

______You have my permission to leave a detailed message or via email:

**Tel.**______-_______-___________ **Email**:_________________________

_____ Please **DO NOT** release **ANY** medical information to anyone other than myself.

_____ I authorize this office to discuss my medical care with the following:

Name________________________ Relationship__________
Tel: ________________________

Name________________________ Relationship__________
Tel: ________________________

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## HIPAA ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read and understood the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

_________________________________ ______/_______/_________
Patient's Signature Date