TERENCE B MITCHELL MD INC

Authorization for Release of Confidential Information

Patient's name: ______________________ Date of birth: ______________________

I hereby authorize the release of medical, psychiatric, alcohol, drug abuse and/or HIV test results or treatment for HIV disease information contained in my records. (This information is protected by Florida Statutes 395.3025; 394.4651; *397.501;* (7); *381.440 and Federal Regulations 42CFR, Part II and CFR 164.524.*

To / From: Dr. Terence B. Mitchell
2600 Partin Drive N, Suite 330
Niceville, FL. 32578
Tel: (850)279-4466 **Fax:** (850)279-6947

To/From: ______________________(Practice(s) to get medical records FROM)

Telephone: ______________________ Fax: ______________________

Address: ____

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Medical Reports/Records requested:

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Dr. Terence Mitchell and that it will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire within 90 days.

Signature of patient or Legal Guardian Date Signed