# NeuroCare Institute of Central Florida, P.A.

*Hal S. Pineless, DO, FACN, FAAN, Board Certified in Neurology*
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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

PATIENT:______________________________________________

DOB:__________________________ SS# ____________________________

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

I authorize______________________________________________

______________________________________________

to release from my medical record, general medical information (FL Statute 395.017) as well as psychiatric/psychological information, alcohol and/or drug abuse information (FL Statute 394.459 and Fed. Reg. 42CFA, Part II), Human Immunodeficiency Virus (HIV) tests and other information pertaining to these tests or to treatment in connection with these test results to:

______________________________________________

______________________________________________

This information will be used for treatment.

______________________________ ____________________
Patient/Legal Guardian Signature Date

______________________________ ____________________
Relationship to Patient Witness

**USE THIS SPACE ONLY IF WITHDRAWING CONSENT**

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect indefinitely unless I specify an earlier expiration date here:______________________.

______________________________ ____________________
Date Revoked Patient Signature

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