CENTRAL FLORIDA INJURY
Rehabilitation
Phone: (407) 831-5100 Fax: (407) 275-9395

AUTHORIZATION FOR MEDICAL INFORMATION (HIPAA compliant)

I,_____, hereby authorize use or disclosure of protect health information about me as described below.

The following specific person, class of persons or facility is authorized to make the requested disclosure: _____

_____

_____

Please release information to CENTRAL FLORIDA INJURY & REHABILITATION CENTER, INC. located at 5555 E. Michigan St., Suite 102, Orlando, FL 32822:

1. The specific information to be disclosed is:

   Full and complete medical records and reports concerning the undersigned's medical or physical condition. This authorization includes but is not limited to reports, x-rays, diagnostics, laboratory reports, in-patient records, out-patient records emergency records.

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

3. I may revoke this authorization by notifying the above named recipient in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

4. This authorization expires on year from the date of execution and a photocopy of this authorization shall be valid as the original.

_____ _____
Patient Signature Representative Capacity, if applicable

_____ _____
Print Name Date of Authorization

_____ _____
Date of Birth Social Security Number (optional)