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**Document 3**

## AUTHORIZATION TO RELEASE, USE AND OBTAIN CONFIDENTIAL MEDICAL/MENTAL HEALTH INFORMATION

***I (Print Name)—>_____ hereby authorize and request, Dr. Evan L. Jacobson and the below listed providers, to release, use, and obtain the following information from my mental health and medical records:***
**history, evaluations, examinations, impressions, studies, diagnoses, formulations, notes and treatments, to and from the following individual(s)/agent(s):**

_____**Phone**_____

_____**Phone**_____

_____**Phone**_____

***In authorizing this release of information, I understand it will be used for the purpose of*** **understanding, coordinating, and determining care and treatment planning both now and in the future.**

***This authorization releases Dr. Jacobson from any and all legal liability that may arise as a result of his compliance with my request. This consent is subject to revocation at any time except that action has already been taken in reliance thereon (In event information has already been released or disclosed).***

**Print Name**_____

**Signature**_____**Date**_____

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501 and/or 90.503 and 42 Code of Federal Regulations. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for privacy of individual identifiable health information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501 and/or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I have been informed that this authorization is subject to revocation by me at any time except to the extent that Fairway Psychiatry has already taken action in reliance on it. Once the requested protected information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Fairway Psychiatry, EJMD, PLLC and Dr. Evan L. Jacobson from all liability should this information be received by someone other than the above-intended recipient.