NPI Established 1970
The Neuropsychiatric Institute

AUTHORIZATION FOR DISCLOURE OF HEALTH INFORMATION

The following individual or organization is authorized to make the following disclosure:

FACILITY NAME: _____

Phone: _____ *FAX (preferred):* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

The information may be disclosed to and used by the following individual or organization:

NEUROPSYCHIATRIC INSTITUTE
4107 W SPRUCE ST SUITE 100
TAMPA FL 33607

FAX: (813) 636-8855
PHONE: (813) 636-8811

PATIENT NAME (please print): _____

SSN: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

This authorizes the above named FACILITY to release general medical, as well as psychiatric and psychological information from my health records in accordance with Florida Statutes 394.459, 480.32 and/or 90.503 and Federal Regulations (42CFR Part 2) and/or HIPAA (CFR 164.508). I understand that the information may include information relating to psychiatric, alcohol, drug abuse, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and laboratory/bloodwork.

- I understand that I have the right to sign this authorization and that the facility named above is released from all legal liability that may arise from not releasing the information requested.
- This consent is subject to revocation at any time except to the extent that the facility which is to make the disclosure has already taken action in reliance on it. Unless otherwise revoked, this authorization *will not expire.*
- I hereby release the above name facility from liability which may arise as a result of the use of information disclosed by this authorization, should it be presumed that such information is later used to my detriment.
- Our Notice of Privacy Practices provides information about our use of a patient's protected health information (PHI). The notice contains a Patient Rights section describing patient's rights under the law.

_____ _____
Signature of Patient or Legal Representative Signature of Witness

_____ _____
Date Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL