DR.KATINA
HEALTH & WELLNESS, LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION

Patient Name:_____

Date of Birth: _____

Telephone Number: _____

Address: _____

REQUESTED FROM

Name of Facility:_____

Address:_____

_____

Telephone Number: _____

Fax Number: _____

Date(s) of Service Requested: _____

Reason for Disclosure: Continuation of Care

Mail, Fax or Email Information to:

Dr. Katina Health and Wellness, Inc.
2901 Coral Hills Drive #330
Coral Springs, Florida 33065
Fax: 954-231-8707
Email: Info@DrKatinaHealth.com

INFORMATION TO BE RELEASED

Complete Medical Record:_____ Operative Reports_____

Pathology Reports: _____ Radiology Reports: _____

Lab Reports: _____ Other (please specify) _____

The following will not be released unless you specifically authorize it by marking the relevant box(es) below:

Drug/Alcohol Abuse or Treatment: _____ Genetic Testing Information: _____

HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses: _____

****Psychiatric Evaluation, Medication Management Notes, Psychological or Psychotherapeutic Notes, and all mental health information_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed. **REDISCLOSURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. **CONDITIONING**: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. **REVOCATION:** I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation 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, Medicaid and Medicare.

Patient Signature: _____ Date Signed: _____

Print Name: _____

Relationship, if Other than the Patient: _____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e.,court-appointed guardian, Durable Power of Attorney for Health Care).

**For a deceased patient: A death certificate coupled with Executor or Administrator of Estate paperwork must accompany authorization; or a court entry or order appointing a Fiduciary, Executor, or Administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the Administrator or Executor of the estate.

****Exception: Parent signing for patient under the age of 18.