DOCCS - Diagnostic & Clinical Care Services
2100 N. Wickham Rd., Melbourne FL 32935
Ph: (321) 259-6007 Fax: (321) 752-7105

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient:_____
Date of Birth:_____ SS#:_____
Patient's Address:_____

The undersigned authorize and/or request DOCCS to:

☐ OBTAIN FROM:

☐ RELEASE TO:

Person/Organization Name:_____
Address:_____
Phone/Fax:_____

Please DO NOT release the following: _____

_____

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment, and/or examination related to mental health care, drug and/or alcohol use, HIV/AIDS testing, and sexually transmitted diseases.
- By signing this release, I understand that this authorization will remain in effect for 90 days or until revoked in writing.
- I understand that state law prohibits the re-disclosure of the information disclosed to the person/entities listed above without my further authorization, but that DOCCS cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- I hereby release DOCCS and the employees of DOCCS from any liability that may arise from the release of information as I have directed.

X_____ _____
SIGNATURE *DATE*

X_____ _____
EMPOWERED REPRESENTATIVE/ GUARDIAN *DATE*

IF THE RECORDS ARE MORE THAN 10 PAGES, KINDLY MAIL THEM TO THE ABOVE ADDRESS. THANK YOU!