BOCA RATON PSYCHIATRIC GROUP, P.A. 7100 W. CAMINO REAL STE 401, BOCA RATON, FL 33433 OFFICE (561) 368-8998 FAX (561) 392-9170

EXCHANGE / RELEASE OF INFORMATION

PATIENT NAME		
D.O.B		
I AUTHORIZE THE RELEASE	OF INFORMATION	
FROM BOCA RATON PSYCHIAT	RIC GROUP TO THE ENTITY LIST	TED BELOW (RELEASE OF INFORMATION)
TO BOCA RATON PSYCHIATRIC	GROUP FROM THE ENTITY LIST	TED BELOW (REQUEST OF INFORMATION)
NAME:		
ADDRESS:		
PHONE:	FAX:	
INFORMATION CONCERNING MY PINFORMATION CONTAINS TREATME ACQUIRED IMMUNE DEFICIENCY S	PSYCHIATRIC TREATMENT. I . ENT NOTES, PSYCHOTHERAPY N SYNDROME (AIDS), HIV AND/OR	ERAL, MEDICAL, INFORMATION AS WELL AS ALSO UNDERSTAND THAT IF MY MEDICAL ROTES, DIAGNOSIS AND/OR TEST RESULTS OF RELATED CONDITIONS, AND/OR SUBSTANCE SED, AND THAT RELEASE MAY INCLUDE
DELIVERY OF WRITTEN NOTICE TO EFFECTIVE UPON THE DATE THE ALREADY FURNISHED TO THE RECI	O THE PROVIDER RELEASING T NOTICE IS RECEIVED BY PRO PIENT BEFORE THE DATE. IN 1	OKE MY CONSENT AT ANY TIME BY THE INFORMATION. CANCELLATION WILL BE OVIDER BUT WILL EXCLUDE INFORMATION THE ABSENCE OF MY WRITTEN NOTICE, THIS TER THE DATE OF CONSENT AS IT APPEARS
SIGNATURE OF PATIENT OR LEGAL I	REPRESENTATIVE	DATE
RELATIONSHIP TO PATIENT (IF LEGA	AL REPRESENTATIVE)	DATE
SIGNATURE OF WITNESS		DATE
WHOSE CONFIDENTIALITY IS PRAND FLORIDA STATUTES PROWITHOUT THE SPECIFIC WRIT	ROTECTED BY FEDERAL LAV DHIBIT YOU FROM MAKIN TEN CONSENT OF THE PE UCH REGULATIONS. BOCA	S DISCLOSED TO YOU FROM RECORDS W. FEDERAL REGULATIONS, CRF PART 2 G ANY FURTHER DISCLOSURE OF IT RSON TO WHOM IT PERTAINS, OR AS RATON PSYCHIATRIC GROUP IS NOT
MAIL RECORDSDATE / INITIALS	F	ILE IN CHART ONLY DATE / INITIALS
FAX RECORDSDATE / INITIALS	F	AX OR MAIL REQUEST DATE / INITIALS