

**SOUTHERN MEDICAL GROUP, P.A.**  
**1401 Centerville Road, Suite 500**  
**Tallahassee, FL 32308**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

**Information To Be Released - Covering the Periods of Health Care**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**Please check type of information to be released:**

_____ Complete health record	_____ History and physical exam
_____ Complete billing record	_____ Laboratory results
_____ Consultation reports	_____ X-ray reports
_____ Discharge summary	_____ Pathology reports
_____ Other (please specify) _____	

**Purpose of Request**

\_\_\_\_\_ Treatment or Consultation  
\_\_\_\_\_ At the request of the patient  
\_\_\_\_\_ Billing or claims payment  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

**Records Are To Be Released From:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Drug, Alcohol Abuse, Psychiatric, and/or HIV/AIDS Records Release**

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

**Drug/Alcohol Abuse**    *Circle One*    Yes    No        **Psychiatric**    *Circle One*    Yes    No

**HIV/AIDS**    *Circle One*    Yes    No

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
SMG Physician

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date