MD DIAGNOSTIC SPECIALISTS
Ronald E. Snyder, M.D.
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Pediatrics

668 North Orlando Avenue Suite #1005 Maitland, FL 32751
Phone 407-644-0101

Authorization to Obtain, Release or Review Protected Health Information

Please fax records to: 407-740-0324

Date ____/____/____ DOB ____/____/____ SS # _____/____/______

Patient Last Name _____________________, First Name______________________

Facility ________________________ Dr. _____________________ DOS ____/____/____

Specific type of information to be disclosed:

□ Discharge Summary □ ER Report □ History & Physical
□ X-ray □ MRI Reports □ CT Scans
□ Consults □ Operative Reports
□ Medical Evaluation / Progress Notes □ Laboratory Results
□ Physical Therapy Notes Dates of Service □ Physical Therapy Office Visit Notes
□ Complete Medical Record □ Psychiatric Evaluation

□ Other ____

I, ______________________________ hereby authorize the physician, his/her authorized designees or medical records personnel, hospital, laboratory or diagnostic center to release my identified protected health information including alcohol and drug abuse records under the regulation in Title 42 C of the Federal Regulations. Part 2 (if any); behavioral medical services record (if any), including communications made by me (the patient) to a social worker or psychologist; and, any information regarding communicable disease and infections as defined by MCLA 333.5131 (if any), which includes venereal disease, tuberculosis, HIV/AIDS, to individuals or organizations listed above, only under conditions listed below:

I understand that my protected health information disclosed under this authorization may be subject to re-disclosure by the individual(s) or organization(s) named above and my (the patient) protected health information will no longer be protected by the law. This authorization is to be used by the physician and will not condition treatment or payment on this authorization. This authorization can be revoked, in writing, at any time except to the extent that information has been released or disclosed. In order for the revocation of this authorization to be effective, the revocation must be in writing and delivered via certified mail. The revocation must include the patient's name, address, social security number, the effective date of this authorization, the patient's desire to revoke this authorization, the date of the revocation and the patient's signature. Authorization for release of disclosure of drug and/or alcohol abuse records shall end when the purpose of the release has been achieved.

Patient's Signature ________________________

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Patient/Legal Representative or Parent/Legal Guardian Signature

(This authorization will expire (six (6) years from the date signed above).