

The
Rice Diet
of Central Florida

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL
INFORMATION**

I, _____, hereby authorize

(Name of hospital, physician, or other entity or individual)

(Address)

(Phone Number)

To release * medical, psychiatric, drug, and/or alcohol abuse or HIV testing, or AIDS information in my records to The Modified Rice Diet Program for the purpose of:

(Specify purpose of disclosure of records)

I understand the specific reports disclosed shall include: _____

(Describe specifically)

I understand that this consent is revocable upon written notice to the office except to the extent the action by the office has been taken in reliance on this authorization, and this authorization shall remain in force for one year unless an earlier expiration date is specified here: _____(date).

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR part II) prohibit making any further disclosure of it without the specific written consent of the undersigned or as otherwise permitted by such regulations. HIV testing and/or AIDS related diagnosis is further prohibited from further disclosure by State Regulations without the specific written consent from the patient.

(Date of Authorization)

(Patient Signature)

(Date of Birth)

(Parent, Legal Guardian, or Authorized Representative Signature)

(Social Security #)

(Witness)

*PATIENT MAY DELETE ANY OF THE CATEGORIES ABOVE BY MARKING THROUGH