AUTHORIZATION FOR
RELEASE OF CONFIDENTIAL INFORMATION

Regarding_____
Print Patient's Name

_____ _____
Social Security Number Date of Birth

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without the written permission of the patient/client/legal representative identified below.

Authorize: DR. JULIAN R. MENENDEZ, D.P.M.
5415 PARK STREET N SUITE C
ST. PETERSBURG, FLORIDA 33709
(727) 544-5425 (727) 544-5440 FAX

To release written general medical information from my medical record (FL Statue 395.017) as well as psychiatric/psychological information, alcohol and/or drug information, (FL Statute 394.459) and Fed. Reg.42cFA, Part II) Human Immunodeficiency Virus (HIV) tests and other information (FL Statute 381.004) pertaining to these tests or to treatment I connection with these test results to:

_____
Name of Facility/Person Holding Information

_____
Address – City/State/Zip

_____
Phone # Including Area Code "Required"

_____ _____
Patient/Client/Legal Representative Signature Date

_____
Signature of Witness