Serenity Health Center, PA

835 Oakley Seaver Drive
Clermont, FL 34711-1968
Tel. 352-241-9282 Fax 352-241-4282

Patient Authorization Disclosure of Confidential Information

I, _____
(Please Print) If you are the legal guardian or parent.
for _____ Date of Birth_____
(Please print the child's name)
by signing this authorization form; authorize the use and disclosure of my health information in the manner described below.

I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of the health information.

I authorize, check all which are appropriate to be used and disclosed.

__ Diagnosis with Medication(s) Prescribed
__ Laboratory Results
__ Outpatient Treatment / Visits
__ Psychiatric Treatment & Services
__ Evaluation Results
__ Other

Please complete a form for **EACH** physician you visit.

I Authorize Serenity Health Center, PA **To Obtain** My Health Information From:
(List any person, practice, business, school etc. with whom Serenity Health Center,PA may communicate with.)

Name: _____ Tel:_____

Address: _____ Fax _____

I Authorize Serenity Health Center, PA **To Release** My Health Information To:
(List person(s), practice(s), employer(s), school etc. which Serenity Health Center, PA may send, give or communicate to.

Name: _____ Tel: _____

Address: _____

_____
Patient or Guardian Signature Date

_____
Witness Signature Date

Expiration Of Authorization: This authorization will expire 365 days from the date of this signing.