

Authorization For Release of Confidential Information

I hereby authorize:

Pursuant to Federal Regulation 42cfr, Part 2 ; Florida Statutes Chapters 381, 394-397 and/or 445.

To Release My : Medical, psychiatric, psychological and/or substance abuse treatment records including HIV test results

In Written Form To :

Efrain Garcia, M.D. P.A.
3661 South Miami Avenue
Suite 702
Miami, FL, 33133

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person(s) or agency. I also understand that I may revoke this release of information at any time provided that I notify the facility and/or physician in writing to this effect, but that revocation has no effect on action taken previously. This authorization shall remain in force until such time that the purpose for which it was given is accomplished or until one year from the time it is dated has passed.

Signature of Patient/Client/Guardian

Date

Name of Patient/Client

Witness Signature

Date

Name of Witness