Instructions: Please complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

☒ **I AUTHORIZE** Ringling College Counseling Center **TO DISCLOSE/RELEASE THE INFORMATION BELOW TO SARASOTA MEMORIAL HEALTH CARE SYSTEM**
NAME OF FACILITY

☒ **I AUTHORIZE SARASOTA MEMORIAL HEALTH CARE SYSTEM TO DISCLOSE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORDS OF:**

1-> Patient's Name: _____
Last First MI

Previous Name If Applicable: _____

2-> Patient's Birth Date_____ Patient's Social Security # _____ Telephone #_____

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO: (Include Address)

Ringling College Peterson Counseling Center fax (941)359-4854
2700 N. Tamiami Trail, Sarasota Fl 34234 tel (941)893-2855

COVERING THE FOLLOWING TIMEFRAME(S) OF HEALTHCARE SERVICES OR CONDITIONS RELATED TO:

_____

FOR THE PURPOSE OF: ❑ Continuing Treatment ❑ Billing ❑ Personal ☒ Other: coordination of care

THE FOLLOWING INFORMATION IS TO BE DISCLOSED/RELEASED:

- ☒ Discharge Summary
- ☒ Operative Report
- ☒ History & Physical Examination
- ☒ Laboratory Tests
- ☒ Consultation Reports
- ❑ Photographs, videotapes, X-rays or other images
- ☒ Cardiology (Imaging) Reports
- ☒ X-Ray (Imaging) Reports
- ☒ Rehabilitation Documentation
- ☒ Emergency Report
- ☒ Abstract (History & Physical, Operative Report, Consultations, Discharge Summary, Discharge Medication Reconciliation Form)
- ❑ Billing Records/Itemized Bill
- ☒ Entire Medical Record – including all dates of service and any conditions treated
- ☒ Other: Mental Health, Medications, Drug Abuse & Alcohol Treatment

I understand that this will include information relating to (initial if applicable):

_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
3-> X_____ Mental Health
-> X_____ Treatment for alcohol and/or drug abuse
_____ Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until separation from Ringling College (date or event). I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System or agency cannot condition treatment upon my signing this authorization.

4-> X_____ _____
Signature of Patient or Legally Authorized Representative* Date

*If other than patient signing, state relationship: _____

5-> X_____ _____
Signature of Witness Date

SARASOTA MEMORIAL HEALTH CARE SYSTEM

AUTHORIZATION TO RELEASE PATIENT INFORMATION

HOSPITAL PERSONNEL ONLY:
Acknowledged by (signature/date):

_____

910532 Rev. 01/11 **MR#**_____ **Processed:** ❑ Yes ❑ No **Number of pages:**_____