James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

Patient Name: ____________________________
Address: ____________________________, _________________, ___, _________
Phone Number: (____) ____ - ______
Date of Birth: _____/_____/_______

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION

(Evaluation, Diagnosis/Testing and/or Treatment for Alcohol and/or Drug Abuse – Federally Assisted Programs, HIV or AIDS and Mental Health).

I hereby authorize that such information regarding the above – named person be forwarded:

FROM: Person/Institution: ____________________________
Address: ____________________________
City: ____________________________ State: ____ ZIP Code: _______
Phone Number: (____) ____ - ______ FAX #: (____) ____ - ______

TO: Person/Institution: ____________________________
(Recipient) Address: ____________________________
City: ____________________________ State: ____ ZIP Code: _______

Disclosure Will Include the Following Verbal Information (*check all that apply*):

☐Face Sheet ☐History & Physical ☐Laboratory/Diagnostic Testing Results ☐School Information
☐Discharge Summary ☐Medication Records ☐Behavior Health/Psychological Consult ☐Psychological Evaluation/Testing Results
☐ER Record Report ☐Psychiatric Evaluation ☐Psychosocial Assessment ☐Summary Treatment Records and Contact Dates
☐Substance Abuse Treatment Record ☐HIV/AIDS Test Results ☐Other____________________________

Records for time period (dates) from: ____/____/______ To: ____/____/______

I have a right to inspect and copy the health mission to be released and if I do not sign this Authorization, the Institute named above will not release my medical/health information. The above-named person/institution will not refuse to treat based on whether I agree to allow the health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation/withdrawal by at a time in line to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

________________________________ ____/____/______
Signature of Patient **Date**

REDISCLOSURE PROHIBITED: notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV/AIDS and mental health treatment without further authorization.