JCE Health
Psychiatry & Functional Medicine
Geidy Rivers, AAPRN, FNP, PMHNP
7530 W Waters Ave, Suite G, Tampa, FL 33615
Office Ph: (813) 400-8632 Office Fax: (616) 236-2059
www.jcehealth.com griversnp@gmail.com

Authorization to Obtain Medical Records Information

Patient Name: _____

DOB: _____ SSN: _____

This will authorize **JCE Health LLC and Geidy Rivers, DNP, APRN** to obtain general medical as well as psychiatric/psychological information from my medical record in accordance with Florida Statues (394.459(b), 381.609 (2)(F), 90.503, 458.21, 396.112, 397.053, 490.32, 90.42. And Federal Law 42CFRII). The obtaining of any information concerning AIDS, Human Immunodeficiency Virus infection. ARC, AIDS-related complex and the performance of any test, counseling and the results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving the status of the purpose contained within this authorization.

The specific information requested is to obtain:

- ☐ All Records
- ☐ Psychiatric Evaluation
- ☐ Treatment plan.
- ☐ Progress Notes (Provider & Clinician)
- ☐ Narrative Summary
- ☐ Psychological Testing
- ☐ Other (Must Specify) _____
- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Laboratory X-ray, EKG, EEG, CT scan
- ☐ Reports of consultations
- ☐ Drug/Alcohol treatment
- ☐ Education
- ☐ Medication Profile

This Information is to be obtained from:

Office Name: _____

Provider(s) Name: _____

Office Phone: _____Office Fax: _____

Office Address: _____

For the purpose of: Assessment and treatment planning / continuity of treatment / Other?

A General Medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information MUST have a waiver from the patient or their empowered representative.

I understand that I have the right to refuse to sign this authorization.

I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by federal regulations and Florida Statutes, and that any re-disclose of this information by the receiving agency is prohibited.

This authorization is for a ☐ single or ☐ continuing disclosure. Valid for 180 days after the date of my signature as it appears below. This authorization may be revoked at any time upon written notification by the signatory or patient, but revocation has no effect on action previously taken.

PATIENT SIGNATURE : _____ TODAYS DATE : _____