



JCE Health
Psychiatry & Functional Medicine
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Authorization to Release Medical Records Information

Patient Name: _____

DOB: _____ SSN: _____

This will authorize **JCE Health LLC and Geidy Rivers, DNP, APRN** to release general medical as well as psychiatric/psychological information from my medical record in accordance with Florida Statutes (394.459(b), 381.609 (2)(F), 90.503, 458.21, 396.112, 397.053, 490.32, 90.42. And Federal Law 42CFR11). The release 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:

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

This Information is to be released to:

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 : _____