



**RELEASE OF PATIENT RECORDS AUTHORIZATION**

Date \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to receive/release a copy of my patient records or x-rays containing protected health information to Rubin Health Center. This authorization is given in pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or patient's representatives.

---

Patient's or Patient's Legal Representative's Signature      Patient's Date of Birth

---

Patient's Name      Social Security #

Specific description of information to be disclosed

---

---

---

**Rubin Health Center**  
**1500 Dr. MLK Jr. Street North**  
**St. Petersburg, FL 33704**  
**Phone (727)822-1555 Fax (727)822-1555**

