



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

