FAU FLORIDA ATLANTIC UNIVERSITY

Louis and Anne Green
Memory and Wellness Center
Christine E. Lynn College of Nursing
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General Authorization for Release of Information

PATIENT NAME:_____ DATE OF BIRTH: _____-_____-_____
LAST FIRST MI MO DAY YR
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ ALT PHONE: _____

The Memory and Wellness Center is authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, adult children, and/or any other family member or friend who may be able to assist with your treatment planning.)

Name: _____ Date added_____ Your Initials_____

Address: _____ Phone:_____

Name: _____ Date added_____ Your Initials_____

Address: _____ Phone: _____

Name: _____ Date added_____ Your Initials_____

Address: _____ Phone: _____

Name: _____ Date added_____ Your Initials_____

Address: _____ Phone: _____

Name: _____ Date added_____ Your Initials_____

Address: _____ Phone: _____

The health information that I am authorizing to be used or disclosed consists of all of the following information:
My medical records and medical history and other information that relates to:

- The diagnosis of any physical and mental conditions
- The treatment and prognosis of any physical and mental conditions

This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions.

PURPOSE OF DISCLOSURE: ___Education ___ Recommendations ___ Care Planning
___ Other (please specify): _____

1. This authorization will expire on _____. If left blank, expiration will occur at such time that you are no longer a patient of the Center.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment, or my eligibility for benefits.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE LEGAL GUARDIAN/AUTHORIZED PERSON DATE