OFFICE OF DR. STEVEN KANFER
CENTER FOR MENTAL HEALTH
806 W De Leon St., Suite 101,
TAMPA, FLORIDA 33606
PHONE (813) 250-0224 ◆ FAX (813) 250-9019

_____ _____
Patient's Name Patient's Social Security #

_____ _____
Patient's Date of Birth Patient's Medical Record

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

By signing below, I authorize the office of Dr. Steven Kanfer M.D. at the Center for Mental Health to exchange with_____ Release to_____ Receive from_____ verbal_____ written_____ Verbal and written_____ information regarding my medical treatment, including psychological/psychiatric and alcohol/ substance abuse treatment information, and HIV/AIDS test results with:

_____
Name

_____
Street Address

_____
City, State, Zip Code

For the purpose of _____

More specifically, please send copies of: (Initial next to either A or B)

A. _____ All records in the custody of _____

B. _____ ONLY the following: (Check records being requested)

_____ Records of Treating Physician _____Only
_____ Evaluation – Initial (Specify Physician's Name)
_____ Progress Notes
_____ Medication Report
_____ Psychological Test Results
_____ X-rays
_____ Lab Results
_____ Verbal Report
_____ Billing
_____ Other: _____

I understand that I may be charged for the copying of these patient records and payment is expected at the time I receive copies from the office of Dr. Steven Kanfer M.D.. This authorization will expire one year after the date of signing.

_____ _____
Patient's or Authorized Representative's Signature Date

_____
Relationship to Patient (Self/Parent/Legal Guardian/Personal Representative/Other)

_____ _____
Witness' Signature Date