



Authorization for Release of Medical Information

Member Name: _____
Social Security: _____
Date of Birth: _____

I authorize _____ (PCP/Facility) to release information that is part of my medical records. This includes alcohol and drug records, mental health records, and information given by me to social workers or psychologists. The following people and/or facilities may receive a copy of my medical records.

Name	Address	Telephone Number
_____	_____	_____
_____	_____	_____

This information is needed for the following reason(s):

Please select one of the options below:

___ I agree to the release of my medical records (may include records listed above).

___ I do not want the following information/records released with my medical records:

- ___ Alcohol record/info
- ___ Drug record/info
- ___ Mental Health record/info
- ___ Report/information from psychologist(s) and/or social worker(s)
- ___ Other. Please list here: _____

I understand that I waive the confidential status of my medical records for the purpose(s) stated above. I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I also understand that I may cancel this authorization at any time by written notice to the above named treatment provider and Simply Healthcare Plans, Inc. I acknowledge that I have read and understand this form and its contents.

Signature of Patient (guardian, if patient unable to sign)

Date

Relation to patient, if signed by guardian

Date

Witness

Date

Simply Healthcare Plans, Inc.
PO Box 830010
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