Delta Medical Associates,LLC
5969 Cattleridge Blvd. Suite # 100
Sarasota, FL 34232-6050
Phone #: (941) 921-3536 I Fax #: (941) 201-1635

INFORMED CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

Patient's Name:	Date Of Birth:
Any Previous Name:	Social Security Number:

Power of Attorney or authorized representative: I (name) _____ hereby request and authorize to release the above Patient's healthcare information to:

OR

I, patient, being of sound mind hereby request and authorize the release of my healthcare information to:

Delta Medical Associates, LLC
5969 Cattleridge Blvd. Suite # 100
Sarasota, FL 34232-6050
Phone #: (941) 921-3536 I Fax #: (941) 201-1635

This request and authorization applies to:

☐ Healthcare information relating only to the following treatment, condition, care, or dates:
_____.
☐ All healthcare information.
☐ Any sexually transmitted diseases, HIV/AIDS whether negative or positive. I understand that Delta Medical Associates, INC., will obtain written permission prior to releasing this information to a third party.
☐ Any records regarding drug, alcohol or mental health treatments.
☐ Other: _____.

This consent applies to:

☐ I hereby give consent for psychiatric evaluation, diagnosis and treatment with medications. I may decline specific treatment or medications at any time.
☐ I hereby give consent for primary care services, evaluation, diagnosis, care, and treatment with medications, I may decline specific treatment or medications at any time.
☐ I hereby give consent for Delta Medical Associates, LLC to obtain or release the above authorized healthcare information with my primary care or any other treating physician.
☐ I hereby give consent for chronic care management services (CCM information provided).

Patient or authorized signature: _____ Date: _____