AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Instructions: PLEASE FILL OUT & SIGN & SEND TO YOUR CURRENT/PAST ADD/ADHD PROVIDER

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _(YOUR NAME)_____hereby voluntarily authorize

(YOUR PROVIDER/MEDICAL OFFICE NAME)_____the disclosure of information from my health record.

Patient Information:

Patient Name: _____Record Number: _____

Address: _____Date of Birth: _____

Information Requested: 1) LETTER OF ADHD/ADD DIAGNOSIS (2) COPY OF ADD/ADHD TESTING REPORT

Purpose of Release: For evaluation, possible treatment, and ongoing management of behavioral health condition by telemedicine

The Information Is To Be Provided To

Name of Person/Organization/Facility:____Today Telemedicine PLLC _____

Address: _____1400 Village Sq Blvd 3-81835 Tallahassee, Fl 32312 _____

Phone Number: ___1- 800-951-8257_____

Preferred fax:_____800-448-2761_____

Alternative email address: ADMIN@TODAYTELEMEDICINE.COM

Patient's Signature or Patient's Representative_____

Date _____

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OFTHIS RELEASE FOR YOUR RECORDS

HIPAA Authorization For Release of Medical Record