DNA Center, LLC.

PERMISSION TO GIVE/SEND INFORMATION

YOUR NAME:_____ **DOB:** _____

This will authorize the ***DNA Center for Neurology and Rehabilitation*** to release general medical information , as well as psychiatric/psychological information, alcohol/drug treatment information, and HIV and AIDS information from any service record in accordance with Federal Law, Title 42, Chapter 1, Subchapter A of the Code of Federal Regulations; Florida Statutes 394, 469, 490, 455, 415, 396, 397, 381.609 to

(Please include family members Names and Relationship)

Address if Mailing _____

The above Florida Statutes include information pertaining to psychiatric/psychological treatment, alcohol and drug treatment, and HIV/AIDS information. This information may be released through verbal, written, or electronic communication.

Records are to be used for Continuity of Care. I understand that I have the right to refuse this authorization or to rescind consent at any time and that the facility named above is released from all legal liability that may arise from the release of information requested. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate when I am no longer an active patient.

Signature of Patient	**DOB**	**Date**
Signature of Empowered Representative	**DOB**	**Date**
Signature of Witness		

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited.

DNA Center, LLC.
1430 Mason Ave
Daytona Beach, FL 32117
(386) 274-2000
Fax (386) 274-7010

PERMISSION TO RECEIVE INFORMATION

Name:_____**DOB:** _____

This will authorize

to release general medical information to The DNA Center LLC in accordance with Federal Law, Title 42, Chapter 1, Subchapter A of the Code of Federal Regulations; Florida Statutes 394, 469, 490, 455, 415, 396, 397, 381.609

The above Florida Statutes include information pertaining to psychiatric/psychological treatment, alcohol and drug treatment, and HIV/AIDS information. This information may be released through verbal, written, or electronic communication.

Records are to be used for Continuity of Care. I understand that I have the right to refuse this authorization or to rescind consent at any time and that the facility named above is released from all legal liability that may arise from the release of information requested. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate when I am no longer an active patient.

Signature of Patient **Date**

Signature of Empowered Representative (if applicable) **Date**

Signature of Witness **Date**

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited.