MEDICAL AUTHORIZATION

PATIENT: _____

DATE OF BIRTH: _____

The undersigned person(s) hereby consents to and, by this signed Authorization (or any photocopy hereof), the release to **BOARD OF COUNTY COMMISSIONERS, ESCAMBIA COUNTY** by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies, of any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse of such patient.

The undersigned understands and hereby acknowledges that the above information or certain portions thereof may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.

This Authorization shall automatically expire without express revocation on conclusion of claim and prior to such time shall be subject to revocation with respect to all or any particular records at any time by the undersigned in writing delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

Signature: _____ Date: _____

Name/Address of Physician:_____

_____

*****

If consent is necessary by a parent, guardian or authorized representative:

Signature: _____ Date: _____

Relationship to Patient: _____