Signature Healthcare of Volusia
Jason R. Mercer, M.D.
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Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected be federal privacy regulations.

Patient Name: _____

S.S. #: _____

Persons/organizations *providing* the information: _____

_____

_____

Persons/organizations *receiving* the information: Jason R. Mercer, M.D.

Specific description of information (includes dates): _____

_____

What is the purpose of the use or disclosure? _____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that this authorization will expire on ____/____/____ (MM/DD/YR)

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative: _____

Date: _____

Printed name of patient's representative: _____

Relationship to the patient: _____

You may refuse to sign this authorization