ATLANTIC COAST MEDICAL CARE, L.L.C.

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RELEASE OF PATIENT RECORDS AUTHORIZATION

I, the undersigned, hereby authorize _____

to release a copy of my patient records or x-rays containing protected health information to

_____.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statue 456.057 (10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative. I further acknowledge that a facsimile of this form be honored as effective and binding as the original.

_____ _____

Signature of Patient or of Patient's Legal Representative — Patient's Date of Birth

_____ _____

Patient's Printed Name — Date Signed

Specific description of information to be disclosed:_____

_____

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