Beth Hanrahan, M.D., L.L.C.
Diplomate
American Board of Internal Medicine

Authorization for Release of Medical Information:

Patient Name:	**DOB:**

I give authorization to the provider listed below to release/disclose a copy of the requested information including HIV testing, psychiatric, alcohol and/or drug abuse, unless otherwise stated for continued medical care:

Physician Name:	
Phone/**Fax:**	

To:
Dr Beth Hanrahan
2495 Enterprise Rd #102
Clearwater, FL 33763
727-724-9656/**727-725-8589**

By checking the boxes below, I authorize the use and disclosure of the following health information:

	Last three years of office notes		Last three years of lab results
	All imaging reports		All procedure reports
	Last office note		Colonoscopy and path report
	Eye exam		Other

I understand this consent is revocable upon written notice to the requested provider or facility, except to the extent that action by the requested party has been taken in reliance on this authorization, and that this authorization shall remain in force for a six month period in order to effect the purpose for which it is given. I understand that if the information is not a health care provider covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other state and federal regulations; the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I understand that requested party may not receive compensation. I understand that if I refuse to sign this authorization it will not affect my ability to receive treatment.

Signed:		**Date:**