I, _____ DATE OF BIRTH: _____
NAME

_____ SOCIAL SECURITY: _____
ADDRESS

_____

AUTHORIZE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) FROM:

SUCCESS BY DESIGN **TO:** NAME: _____

9095 BELCHER ROAD ADDRESS: _____

PINELLAS PARK, FL 33782 _____

PH: 888-530-0599 / FAX: 727-258-4865 PH: _____ FAX: _____

This authorization expires _____ (unless otherwise stated, authorization expires six (6) months from date of authorized signature)

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

I want the following information to be disclosed: (Required- Please Specify):

_____

Purpose of this disclosure is: (Required – Please Specify):

_____

Please be aware that information disclosed pursuant to this authorization is subject to Re-disclosure by the recipient and is no longer protected by this organization.

_____ Date: _____
Signature of Patient or Representative (Required)

_____
If representative, authority on which acting for the patient.