Aida Murko, M.D., P.A.
Diplomate, American Board of Psychiatry and Neurology
Child, Adolescent and Adult Psychiatry

Zoran Murko, M.D., P.A.
Diplomate, American Board of Psychiatry and
Neurology Geriatric and Adult Psychiatry

AUTHORIZATION FOR OBTAINING AND RELEASING CONFIDENTIAL INFORMATION

I, _____ of _____
(Name) (Address)

_____
(City, State) (Zip code)

Date of Birth: _____ Social Security Number: _____

Authorize: **Dr Murko M.D. P.A.**

☐ To Obtain
☐ To Release

( ) Verbal Exchange	( ) Discharge Summary	( ) Interdisciplinary Assessments
( ) Radiology Results	( ) Progress Notes	( ) Physician Orders
( ) Admission Evaluation	( ) Psychiatric Evaluation	( ) History and Physical
( ) Psychological Testing	( ) HIV Testing	( ) Laboratory Results
( ) Treatment Plan(s)	( ) Medication Records	( ) Treatment Summary
( ) Other _____		

To / From: _____

Address _____

Telephone: _____ Fax:_____

I hereby authorize Dr. Murko to release / obtain copies of Psychiatric, Drug and Alcohol, HIV, and Medical information from the health care record pertaining to hospitalization / treatment for ___All Dates___ (specify dates or treatment) by mail, courier, telephone conversation, electronic mail, or facsimile transmittal to or from .

These records are required for the purpose of: (check at least one)
☒ Providing information to health care providers ☐ Legal Purposes ☐ Social Security / Disability
☐ Other: (specify) _____

Please initial the following:

_____ I understand that my healthcare and payment for health care will not be affected if I do not sign this form, and I am entitled to a copy of this from (upon request) after I sign it.

_____ I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that this authorization expires exactly three years from the date of my signature below.

_____ I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the Medical Records Department at the office of Dr. Murko.

This information has been disclosed from confidential records protected by state and federal laws; those that are more stringent will apply. Any further disclosure of this information is not permitted without specific authorization to do so.

I certify that I have read and fully understand the content of this page.

Signature of Patient: _____ Date: _____

Signature of Parent / Guardian _____ Date: _____