Authorization for the Release of Protected Health Information

Date Requested: _____
Expire ones year from requested date unless otherwise specified: _____

To: Anthony I. Sebba, MD
Address: 33920 US Hwy 19 N Ste 241
Palm Harbor, FL 34684

Phone: (727) 773-9793 Fax: (727) 773-0674

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including psychiatric and or psychological information which may be part of my medical records for the purpose of:

Please forward to: _____

Address: _____

_____

_____ _____
Signature of Patient/Legal Guardian Patient Date of Birth

_____ _____
Print Name of Patient or Legal Guardian Date