BAY HILL PSYCHIATRIC ASSOCIATES LLC

6068 South Apopka Vineland Road, Suite 3, Orlando, FL 32819
407-903-9696

Syeda N. Sultana, M.D.

Board Certified Child, Adolescent & Adult Psychiatrist

RELEASE OF INFORMATION

Required by the Health Insurance Portability and Accountability Act --- 45 CFR Parts 160 and 164

I hereby Authorize: Bay Hill Psychiatric Associates, LLC
Syeda N. Sultana, M.D.
Fax: 407-903-9698

To:
a. Release information to:
b. Obtain information from:
c. Exchange information with:

Doctor's Name: _____
Office Name: _____
Address: _____
_____
Phone: _____
Fax: _____

The information requested or authorized for release or exchange pertains to:

a. Mental Health
b. Education
c. HIV/Transmitted disease
d. Drug or alcohol abuse

This authorization is valid for 90 days from the date below or_____, whichever is earlier. I may cancel this authorization by signing, dating and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it; my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my health evaluation and/or treatment.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient Signature Date

Signature of the witness: _____ Date: _____

Guardian's signature and date (if patient is a minor and/or unable to sign for him/herself).

_____ _____
Patient's Name (Printed) Date