

**Dr. Isidoros Mereos
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**Patient Authorization for Use and Disclosure of Protected Health
Information to Third Parties**

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that if the organization to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Name of patient: _____

Address: _____

Telephone: () _____

Information to whom records should be sent to:

Name of Doctor/Practice: _____

Address: _____

Telephone: () _____

Specific description of information (including date(s)):

Printed name of patient: _____

Signature of patient or Guardian (if minor): _____