

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

<p>PATIENT INFORMATION</p>	<p>NAME: _____</p> <p>DOB: _____ SS# _____</p> <p>Address: _____</p> <p>City: _____ State _____ Zip: _____</p> <p>Day Phone: _____</p>
<p>Who has the information you want released?</p>	<p>NAME: _____</p> <p>Address: _____</p> <p>City: _____ State _____ Zip: _____</p> <p>Phone: _____ Fax: _____</p>
<p>Where do you want the information sent?</p>	<p>NAME: _____</p> <p>Address: _____</p> <p>City: _____ State _____ Zip: _____</p> <p>Phone: _____ Fax: _____</p>
<p>What information do you want sent or released? (Check all that apply.)</p>	<p>Indicate dates of service: _____</p> <p><input type="checkbox"/> Prenatal Records <input type="checkbox"/> Pap smear/s <input type="checkbox"/> Pathology Report/s</p> <p><input type="checkbox"/> Breast Imaging Report/s <input type="checkbox"/> Gyn Sono Report/s <input type="checkbox"/> Perinatal Report/s</p> <p><input type="checkbox"/> Lab result/s ❖ HIV DIAGNOSIS MAY BE DISCLOSED WITH LAB RESULTS ❖</p> <p><input type="checkbox"/> Other: _____</p>
<p>How do you want the information delivered?</p>	<p style="text-align: center;">(NOTE: REQUEST TAKE 7-10 BUSINESS DAYS FOR PROCESSING)</p> <p><input type="checkbox"/> Mail <input type="checkbox"/> Patient will pick up (fees apply)</p> <p><input type="checkbox"/> Fax <input type="checkbox"/> Pick up by: _____ (fees apply)</p>
<p>Purpose of Release (Why is it needed?)</p>	<p><input type="checkbox"/> Transfer of care to new physician <input type="checkbox"/> Continuing care/Second opinion</p> <p><input type="checkbox"/> Other: _____</p>

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 treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Gentle Gynecology from all liability arising from this disclosure of my health information. **I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. For patients and governmental entities: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. For other entities: up to \$1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.**

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date: _____

Patient, Parent, Guardian or Legal Representative Signature: _____