



Authorization to Release Medical Records

Please read and complete ALL sections

Patient's Legal Name: _____ Date of Birth: _____

I authorize the following provider to release my protected health information:

Premier Women's Care of Southwest Florida
1265 Viscaya Parkway, Cape Coral, FL 33990

Medical Records Phone: (239) 800-7412 or (239) 800-7441 / Fax: (239) 482-6297

Information to be released to: _____

Note: if you are releasing records to yourself, please write **SELF**

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Specific Information to be disclosed: (check all that apply):

- Medical Record from (insert date) _____ to (insert date) _____ Note: Write **ALL** if you want **all years**

Complete Health Record (or specify below / does not include Special Authorization testing) _____

Office Notes _____ Diagnostic Reports _____ Pap/ HPV results _____ Laboratory Reports _____

Pathology Reports/Biopsies _____ Surgery Reports _____ Treatment Notes _____

Other (please specify) _____

Special Authorization testing: (check any additional testing you would like included in this release):

HIV/AIDS testing _____ STD (sexually transmitted) testing _____ Genetic Testing _____

Psychological/Psychiatric (except psychotherapy notes) _____ Drug, Alcohol and Substance Abuse Treatment _____

Reason for disclosure: (please circle):

Continuation of treatment Transfer of Care Legal Issue Insurance Change Personal Other _____

Please check choice: _____ Fax Records / Fax Number: _____

_____ E-mail Records / E-mail Address: _____ Mail Records

Medical Record Fee:

\$1 per page up to 25 pages then, \$0.25 per additional page. In addition to the medicals record fee, if records are sent by **Mail** a S&H fee may apply (In-state: \$5, Out-of-State \$10, Out-of-Country \$25). There is no charge for Electronic Delivery.

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the Information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of Premier Women's Care of Southwest Florida, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Premier Women's Care of Southwest Florida in reliance on this authorization, by sending a written revocation to Premier Women's Care of Southwest Florida, 1265 Viscaya Parkway, Cape Coral, FL 33990 Attention: Medical Records.

I understand that this authorization is valid for up to one year from the date I sign it, unless I specify otherwise. I also understand that I may be charged for copies of my medical records as allowable under Florida Administrative Code Rule: 64BB-10.003. Further, I understand that I will not be denied or refused treatment if I refuse to sign this authorization.

Signature of Patient or Legal Representative

Date

Relationship to Patient

STATEMENT OF CONFIDENTIALITY: The information contained in this facsimile message is a client privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message IS NOT the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail at the above address via the US Postal Service. Thank you.