



Authorization for Request of Medical Record Information:

Please read and complete out ALL sections carefully

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

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

Name of Office / Healthcare Provider: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Information to be released to:

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 disclosed: (initial all that apply):

Complete Health Record _____ Office Notes _____ Diagnostic Reports _____ Pap Smears _____

Laboratory Reports _____ Pathology Reports/Biopsies _____ Genetic Testing _____

Surgery Reports _____ HIV/AIDS testing _____ Psychological/Psychiatric Notes/Treatment _____

Substance Abuse Treatment _____ Other (please specify) _____

Please initial choice: _____ Fax Records _____ Mail Records _____

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.

I understand that this authorization is valid for up to six months 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