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) 482-7528

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

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