PREMIER WOMEN'S CARE OF SOUTHWEST FLORIDA

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) 482-7528

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: _____
_____ Mail Records

<u>Medical Record Fee</u>:
$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 **<u>Mail</u>** 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