

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

OBGYN ASSOCIATES PA
2400 N. Orange Blossom Trail
Suite 300
Ph-407-846-7200 Fax-407-846-3989

I, _____ hereby authorize: DOB _____

(Name of individual, Hospital, Doctor's office or Agency)

(Complete address & Phone Number)

to release medical, psychiatric, alcohol, AND/OR drug abuse, HIV testing, ARC AND/OR AIDS diagnosis, eating disorders information or any medical records of sensitive nature to:

(Name of individual, Hospital, Doctor's office or Agency)

(Complete address & Phone Number)

For the purpose of _____ (ex-continued care, transfer of care, PCP)

The specific report to be disclosed shall include (ex. All records, mammo, sono, pathology, etc..)

I understand that this consent is revocable upon written notice to the doctors, except to the extent that action has already been taken on this authorization. This authorization shall remain in force until _____, or for a reasonable time to accomplish the purpose for which it is given. Alcohol and drug information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

By copy, fees for copying are \$1.00 per page for first 25 pages, and .25 for each copy thereafter

Date of Authorization

Patient Signature (full name)