Women's Care Florida
Exceptional Women's Care for Every Patient, Every Time

Authorization to Obtain, Release or Review Protected Health Information (PHI)

I _____
(Print Name) (DOB) (SS#)

hereby authorize Women's Care Florida

Please check one:

- ❑ to obtain from Dr.
- ❑ to release to Dr.
- ❑ to release to me (enter your home address below)

_____
(Name of Doctor) (phone #)

_____
(Address) (Fax #)

- ❑ All medical information and reports
- ❑ Prenatal medical records
- ❑ Physical examination reports
- ❑ Laboratory reports
- ❑ Immunizations
- ❑ Radiology (x-ray) reports
- ❑ Sexually transmitted disease reports
- ❑ Psychiatric/Psychological reports
- ❑ HIV/AIDS test results
- ❑ Other (please specify) _____

Please specify anything that you do NOT want to be released:

_____

The purpose of the release of information:

_____

Women's Care Florida may not condition treatment or payment on whether the patient signs this Authorization unless permitted by law.

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of **7-10 business days.**

_____
Patient/Legal Representative or Parent/Legal Guardian Date