



All About Women

Obstetrics & Gynecology

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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

SS Number: _____

Telephone: _____

Other names used: _____

I authorize and request that you release as directed:

From or To

All About Women OB-GYN
6440 West Newberry Road, Suite 111
Gainesville, FL 32605
Phone # (352) 331-3332
Fax # (352) 331-3320

From or To

Dr/Hospital name: _____
Address (optional): _____
Address line 2 _____
Telephone: _____
Fax: _____

Please release the following records:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pap Results |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | _____ |

Personal health information regarding testing and treatment for drug abuse, mental health conditions, and HIV/AIDS must be **specifically** authorized. My signature authorizes all of this information to be released unless I specifically request that the following information is withheld. By checking the spaces below,

I DO NOT authorize the release of personal health information regarding these conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mental Health | <input type="checkbox"/> HIV / AIDS |
|--|---|--|

I **allow** information to be transmitted by **fax**. I understand that this may limit the security or confidentiality of the information transmitted.

I **do not allow** information to be transmitted by **fax**.

I understand that this authorization expires upon completion of the task or 60 days after signature, whichever comes first. I may rescind this authorization in writing at any time. I may limit information released by explaining my preferences on a separate sheet of paper. I also acknowledge that I have read and fully understand this authorization.

X _____
(Patient Signature)

(Date of Authorization)

X _____
(or Patient Representative)