All About Women
Obstetrics & Gynecology
Anthony B.Agrios, MD
Jean Cook, MD
Joseph Iobst, MD
K. Nicole Scogin, MD
Shelley Russell, CNM
Julie Rischar, CNM
Kristen Cook, CNM

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 ☐	From ☐ or To ☐
All About Women OB-GYN	Dr/Hospital name: ____________________
6440 West Newberry Road, Suite 111	Address (optional): ____________________
Gainesville, Fl 32605	Address line 2 ____________________
Phone # (352) 331-3332	Telephone: ____________________
Fax # (352) 331-3320	Fax: ____________________

Please release the following records:

___ **ALL RECORDS**	___Radiology Reports	___Pap Results
___Laboratory Reports	___Discharge Summaries	___Other ____________________
___Progress Notes	___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:

___Drug Abuse **___Mental Health** **___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)