All About Women
Obstetrics and 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 ☐	**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 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)