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 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)

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