



All About Women Obstetrics and Gynecology

Anthony Agrios, MD, Joseph Iobst, MD, Jean Cook, MD, K. Nicole Scogin, MD

Shelley Russell, CNM, Kristen Cook, CNM, Cynthia Vista, CNM, Katie Camargo, CNM, Ronnie Jo Stringer, 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

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:

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)

