

All About Women Advanced Gynecology

Anthony B. Agrios, MD
Sheyna Carroccio, MD
Rosie Foran, APRN
Lacey Newell PA-C
Julie Davey, APRN
Janice Baucom, APRN
Casey Chapman, APRN

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
3780 NW 83rd Street
Gainesville, FL 32606
Phone # (352) 331-3332
Fax # 844-735-8442

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 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)