OB • GYN CARE
ORLANDO
Women's Health & Anti-Aging

Authorization to Request Medical Information

______________________________ Print patient's full name

______________________________ Birth Date (mo/day/year)

______________________________ Street address

______________________________ SSN#

______________________________ City, state, zip code

______________________________ Phone number

I hereby authorize ***OB/Gyn Care Orlando*** to request my medical records from the facility listed below:

______________________________ Name of Company/Agency/Facility/Person

______________________________ Street Address

______________________________ Phone number

______________________________ City, state, zip code

______________________________ Fax number

Dates of ________________________

(Please circle)

Discharge Summary	History & Physical	Progress Notes
Operative Notes	Pathology Reports	Laboratory Reports
Radiology Reports	ECG/EEG/Cardiac Cath	Emergency Reports
All Records	Other______________	

I do / I do not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of health information for the above named patient to *OB/Gyn Care Orlando*. This authorization is valid for 12 months from the date of signature. I understand I may cancel this request with written notification but it will not affect any information released prior to notification of cancellation. I understand the written information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________ Printed Name/Responsible Party

______________________________ Date

______________________________ Signature of Patient/Responsible Party