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BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

COMPREHENSIVE OB-GYN OF THE PALM BEACHES, LLC

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Record Release

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize any or the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to **Release** Information	
Address (Street Address, City, State, Zip Code)	
Phone Number	Fax Number

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to **Receive** Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Release records from year _____to _____

- Treatment of communicable diseases, sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis, Alcohol or Substance Abuse Treatment, Mental Health Information or Psychological Conditions
- Pap and Culture, Lab Work, Genetic Testing, HIV-Related Treatment
- Bone Density, Mammogram Reports, Mental Health Information or Psychological Conditions
- Other:_____

- Reason: Change of Doctor___ Attorney/Legal___ Insurance___ Personal___ Other_____

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I understand and agree that the health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. I have read (or had read to me) this authorization and by my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions.

I understand that if my records are to be released to anyone other than my current physician, I or third party, will be subjected to pay $1 per page for the first 25 pages and $0.25 per page after.

Signature of Patient or personal Representative	Date Signed	Description of Personal Representative's Authority