AUTHORIZATION TO RELEASE HEALTH INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____BIRTHDATE: _____

I AUTHORIZE: ***MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE***
1301 PLANTATION ISLAND DRIVE, SUITE 103
ST. AUGUSTINE, FL 32080
PHONE 904-461-5330 - FAX 1-855-279-4391

_____ Receive my records from

_____ Release my records to

NAME OF DOCTOR, HOSPITAL, ETC _____

ADDRESS _____

CITY/STATE/ZIPCODE _____

PHONE # _____FAX # _____

FOR THE PURPOSE OF REVIEW/EXAMINATION, I FURTHER AUTHORIZE YOU TO PROVIDE SUCH COPIES THEREOF AS MAY BE REQUESTED. THE FORGOING IS SUBJECT TO SUCH LIMITATION AS INDICATED BELOW:

( ) ENTIRE RECORD

( ) SPECIFIC INFORMATION _____

REASON FOR REQUEST _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. I DO EXPRESSLY AND VOLUNTARILY CONSENT TO THE DISCLOSURE OF THE INFORMATION CHECKED ABOVE TO THE PERSON/DOCTOR/AGENCY NAMED ABOVE. I UNDERSTAND THAT IF THE PERSON(S) AND/OR ORGANIZATION(S) LISTED ABOVE ARE NOT MANDATED BY THE FEDERAL PRIVACY STANDARDS, THE HEALTH INFORMATION DISCLOSED AS A RESULT OF THIS AUTORIZATION MAY BE REDISCLOSED WITHOUT MY AUTHORIZATION. I UNDERSTAND THAT I MAY BE CHARGED A FEE FOR COPYING THESE MEDICAL RECORDS.

SIGNED _____DATE _____

WITNESS _____