Gentle Gynecology & Obstetrics

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AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

PATIENT INFORMATION	**NAME:** _____ **DOB:** _____ **SS#** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Day Phone:** _____
***Who* has the information you want released?**	**NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone:** _____ **Fax:** _____
***Where* do you want the Information sent?**	**NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone:** _____ **Fax:** _____
***What information* do you want sent or released?** **(Check all that apply.)**	**Indicate dates of service:**_____ ❑**Prenatal Records** ❑**Pap smear/s** ❑**Pathology Report/s** ❑**Breast Imaging Report/s** ❑**Gyn Sono Report/s** ❑**Perinatal Report/s** ❑ **Lab result/s** ❖**HIV DIAGNOSIS MAY BE DISCLOSED WITH LAB RESULTS**❖ ❑ **Other:**_____
***How* do you want the information delivered?**	**(NOTE: REQUEST TAKE 7-10 BUSINESS DAYS FOR PROCESSING)** ❑**Mail** ❑**Patient will pick up (fees apply)** ❑**Fax** ❑**Pick up by:**_____ **(fees apply)**
Purpose of Release **(*Why* is it needed?)**	❑**Transfer of care to new physician** ❑**Continuing care/Second opinion** ❑**Other:**_____

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Gentle Gynecology from all liability arising from this disclosure of my health information. **I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information.** ***For patients and governmental entities*: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages.** *For other entities*: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ **Date:** _____

Patient, Parent, Guardian or Legal Representative Signature:_____

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