AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

University OBGYN
OBSTETRICS & GYNECOLOGY CARE

TopLine MD Alliance

Patient Information

Patient's Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Day Phone #:_____ Social Security #:_____

Practice Information

Practice Name:_____ Physician:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____

Where do you want the records to be sent?

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____

What records do you want sent or released?

(Please specify the years of records you wish to be sent or released)

Record Name	Years	Record Name	Years	Record Name	Years

How do you want the information delivered? *(Requests 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 University Park OBGYN, LLC 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.

Patient Name (Please Print):_____ Date:_____

Signature:_____
(Patient, Parent, Guardian or Legal Representative)