Authorization to Obtain, Release or Review Protected Health Information (PHI)

I ____

(Print Name) (DOB) (Last 4 digits of your SS#)

hereby authorize Women's Care Florida, and/or its affiliates,

Please check one:

- ❑ to obtain records from my Healthcare Provider
- ❑ to release records to my Healthcare Provider
- ❑ to release records to me (enter your home address below)

____

(Name of Healthcare Provider) (Phone #)

____

(Address) (Fax #)

Please check all that apply:

- ❑ All medical information and reports
- ❑ Prenatal medical records
- ❑ Physical examination reports
- ❑ Laboratory reports
- ❑ Immunizations
- ❑ Radiology (x-ray) reports
- ❑ Sexually transmitted disease reports
- ❑ Psychiatric/Psychological reports
- ❑ HIV/AIDS test results
- ❑ Other (please specify) ________________________________

Please specify anything that you do NOT want to be released:

____

The purpose of the release of information:

____

Women's Care Florida may not condition treatment or payment on whether the patient signs this Authorization unless permitted by law. There may be a cost-based fee associated with your request, allowable under HIPAA, which may not exceed the maximum allowable under current law.

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of approximately **7-10 business days.**

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Patient/Legal Representative or Parent/Legal Guardian Date

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Printed Name (if signed by Parent/Legal Guardian/Representative other than the patient)