ADVANCED WOMEN'S HEALTH SPECIALISTS
Obstetrics, Gynecology & Infertility

407-834-8111 (phone)
844-233-8377 (fax)

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records.

Patient Name: _____ Date of Birth: _____

A) I hereby authorize records from:

Name/Company:_____

Phone#:_____

Fax#:_____

B) To be released to:

Name:_____

Address:_____

City/State/Zip:_____

Phone#:_____

Fax#_____

The information you may release subject to this signed release form is as follows:

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__Complete Records __History and physical __Progress Notes
__Care Plan __Lab Reports __Radiology Reports
__Pathology Reports __Treatment record __Operative Reports
__Hospital Records __Medication Record __Other (please specify) _____

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I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand that the information in my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that id I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the laws provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of patient/Parent/Guardian or Authorized Representative Date

The authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date)