



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

I _____
(Print Name) (DOB) (SS#)

hereby authorize **Women's Care Florida**

Please check one:

- to obtain from Dr. _____
- to release to Dr. _____
- to release to me (enter your home address below)

(Name of Doctor) (Phone number)

(Address) (Fax number)

- All medical information and reports
- Prenatal medical records
- Physical examination reports
- Laboratory reports
- Immunizations
- Radiology reports and images
- 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:

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 **7-10 business days**.

Patient/Legal Representative or Parent/Legal Guardian Date