SUNCOAST OB/GYN
All Women's
Midwifery & Health Care

Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____
Address: _____
City/State/Zip code: _____
SSN: _____-_____-_____ Patient's phone #: (___) _____-_____
Date of Request: _____ Upcoming appointment date: _____

I authorize Suncoast OB/GYN All Women's to Release	I authorize Suncoast OB/GYN All Women's to Obtain
Information TO: _____	Information FROM: _____
Name of Provider: _____	Name of Provider: _____
Address: _____	Address: _____
City/State/Zip code: _____	City/State/Zip code: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Purpose of request: (check one) Healthcare _____ Personal _____ Transfer of Care _____ Other _____

Type of Records Requested: (check one)

_____ Copy of entire medical record

_____ Specific information (select one or more, as applicable) Date range: _____-_____

_____ Procedure report _____ History & Physical _____ Physical therapy _____ Lab reports_____

_____ X-ray/ultrasound reports _____ Other:_____ (please describe)

Authorization valid for: (check one)

_____ This request only

_____ One year from the date of this authorization OR _____. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

* My right to healthcare treatment is not conditioned on this authorization.
* I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
* If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
* Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information require additional authorization.
*There may be a charge for requested records.

Signature of Patient/Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

□ **11373 Cortez Blvd., Suite 207 Brooksville, FL 34613 Ph: (352) 596-8911 Fax: (352) 596-5636**
□ **4003 Mariner Blvd., Spring Hill, FL 34609 Ph: (352) 263-2600 Fax: (352) 684-2218**