ob·gyn women's centre of Lakewood Ranch, LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY REQUEST AND AUTHORIZE: OB/GYN WOMEN'S CENTRE OF LAKEWOOD RANCH, LLC

❑ JORGE E. ALVAREZ, MD ❑ JENNIFER R. MCCULLEN, MD ❑ EDGARDO J. APONTE, MD
❑ M. JOANNE BEVERS, CNM, MSN ❑ THERESE E. GOODE, PA-C

TO: ❑ OBTAIN FROM DOCTOR'S NAME _____

❑ SEND TO DOCTOR'S ADDRESS/FAX _____

THE FOLLOWING MEDICAL INFORMATION

❑ ALL MEDICAL RECORDS ❑ SPECIFIC INFORMATION

❑ SPECIFIC INFORMATION
I WISH TO HAVE RELEASED: _____

FOR THE MEDICAL RECORDS OF: (PLEASE PRINT)

PATIENT'S
NAME _____ D.O.B. _____ SSN _____

I understand that I may revoke this consent at any time, by submitting such a request in writing, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

SIGNATURE _____ DATE _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

❑ I DO consent to have this information disclosed ❑ I DO NOT consent to this information being disclosed.

SIGNATURE _____ DATE _____

This medical record may contain information concerning HIV testing and / or AIDS diagnosis. Separate consent must be given before this information can be disclosed.

❑ I DO consent to have this information disclosed ❑ I DO NOT consent to this information being disclosed.

SIGNATURE _____ DATE _____

REASON FOR REQUESTING RECORDS: _____

SIGNATURE _____ DATE _____

If records are less than 10 pages, please fax. If records exceed 10 pages, please mail.

OB/GYN WOMEN'S CENTRE OF LAKEWOOD RANCH, LLC RESERVES THE RIGHT TO CHARGE A FEE FOR THE SERVICE OF COPYING MEDICAL RECORDS. THERE WILL BE A MINIMUM FEE OF $15.00 FOR THIS SERVICE. OUR OFFICE DOES REQUIRE A MINIMUM OF 72 HOURS PRIOR NOTIFICATION FOR COPYING OF MEDICAL RECORDS.

PHONE #: (941) 907-3008 **FAX #: (941) 907-3036**

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