OB/GYN Women's Centre of Lakewood Ranch

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ _____

I request and authorize _____
(Name of previous facility where you had mammogram done)

To release healthcare information of the patient named above to:

OB/GYN Women's' Centre of Lakewood Ranch
8340 Lakewood Ranch Blvd #240
Lakewood Ranch, FL 34202
Phone (941) 907-3008 Fax. (941) 907-3036

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: **Mammography DVD and Reports**

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

For Internal use only:

Faxed Date: _____ Received Date: _____ Appt. Schedule: _____