



**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  
 ELISSA BARFOOT, APRN, CNM, FNP-C       JENNIFER LESOWITZ, DNP, CNM, APRN       JILL S. MILLER, APRN       BRANDY THOMAS, CNM

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**

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