HIBISCUS
WOMEN'S CENTER

Patient Name:_____

Social Security Number: (not required)_____

Address:_____ Date of Birth:_____

_____

From (date): _____ To (date): _____ Phone:_____

RELEASE MEDICAL RECORDS FROM:

NAME

ADDRESS

CITY, STATE, ZIP

PLEASE SEND MY RECORDS TO: (please provide as much information as possible, including fax number if necessary)

NAME: FAX:

ADDRESS:

CITY, STATE, ZIP:

I, _____, give authorization for your office to release the following information: (if applicable):

- ❑ Complete Health Record
- ❑ OB Record
- ❑ History and Physical
- ❑ Progress Notes
- ❑ Consultation Reports
- ❑ Operative Reports
- ❑ Physician Orders
- ❑ Discharge Summary
- ❑ Special Procedure(s) (please specify)_____
- ❑ Laboratory Test(s) (please specify)_____

Other (please specify)_____

If applicable, I also give permission for the following to be disclosed **(please initial)**:

_____acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)

_____behavioral health services/psychiatric care

_____treatment for alcohol and/or drug abuse

I understand that the release or transfer of the information specified to any person or entity not specified above is prohibited. I hereby release the originating office or facility, its employees, officers and physicians from any legal responsibility or liability that may arise from complying with this authorization. I understand that the medical record maintained by the doctor may contain medical and administrative information from other healthcare providers. I also understand that the doctor is authorized by Florida law to charge me for duplication costs incurred in connection with copying my medical records

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date _____. If I fail to specify an expiration date, this authorization will expire in twelve (12) months.

_____ _____

Signature of Patient or Legal Representative (Relationship) Date

_____ _____

Signature of Office Representative (Witness) Date

330 E. Hibiscus Blvd., Melbourne, Florida 32901 321-724-2229/321-728-6681 (fax)