AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____ SSN_____ DOB _____

Give permission for:

Doctor Name: _____

Address: _____

Phone: _____ Fax: _____

To release records to:

ALL ABOUT WOMEN OBGYN

70 DOCTORS DRIVE

PANAMA CITY, FL 32405

(850)785-1517 Fax (850)784-1271

This authorization applies to:

____Healthcare information relating to the following treatment, condition or dates:
_____

____All healthcare information

____Other:_____

____ I authorize the release of any STD, HIV/AIDS results regardless if positive or negative.

____ I authorize the release of any drug, alcohol, mental health treatment.

I understand that once information is released to ALL ABOUT WOMEN OBGYN my information may be subject to re-disclosure if another facility/doctor deems is necessary for treatment of my personal health. I also understand that once information is released it may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.

Patient Signature: _____ Date: _____