Patient Name: ______________________________ Date of Birth: ______________________

Address: __________________________________ City: ________________ Zip: _________

Phone Number: _____________________________ Last Four of SS# Only: ______________

Please send the requested information below:

Entire Medical Record: ____ Office Notes: _____ Test Results: ____ Radiology Reports: ____
Referrals: _____ Consults: ______

Reason for the request: Transfer of Care: _____ Healthcare: _____ Personal: _______

I authorize Orange Blossom Women's Group to obtain records from:

Provider Name: ____________________________

Address: _________________________________

City, State, Zip: ___________________________

Phone number: ____________________________

Fax number: ______________________________

I authorize Orange Blossom Women's Group to send records to:

Provider Name: ____________________________

Address: _________________________________

City, State, Zip: ___________________________

Phone number: ____________________________

Fax number: ______________________________

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 12 months following the date of my signature shown below. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature:__________________________ Date: ___________________________

Office Use Only

Received Date:______________________ Date Faxed: _______________________

Orange Blossom Women's Group 2043 Little Road Trinity, Fl 34655
Phone (727) 846 - 7000 Fax: (877) 260-1182