Orange Blossom
WOMEN'S GROUP

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