Sarasota OB/GYN Associates
2439 Bee Ridge Road Sarasota, FL 34239
Phone: (941)343-0609
Fax: (941)378-9120

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

NAME: _____ DATE OF BIRTH: _____

SSN: _____

I hereby authorize Dr. Wayne A. Cohen, M.D., FACOG / Beth Hinkelman, WHNP,RNC,MPH / Elizabeth Gutierrez, CNM to:

- ☐ Receive my records from
- ☐ Release my records to

PHYSICAN/ORGANIZATION: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

The purpose for need of disclosure is for the following reason(s):

_____

The specific information I wish to have released is:

_____

I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Sarasota OB/GYN Associates will not be able to release my records to another provider without proper authorization. If I decide not to sign this authorization Sarasota OB/GYN Associates will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information listed to the person/physician/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be disclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE: _____ DATE: _____

EXPIRATION: This authorization is good until the following date(s) _____ or for six months from the signed date.