PREMIER
WOMEN'S CARE
OF SOUTHWEST FLORIDA

Authorization for Request of Medical Record Information:

Please read and complete out ALL sections carefully

Patient's Legal Name: _____ **Date of Birth:** _____

I authorize the following provider to release my protected health information:

Name of Office / Healthcare Provider: _____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone: _____ **Fax:** _____

Information to be released to:

Premier Women's Care of Southwest Florida

1265 Viscaya Parkway

Cape Coral, FL 33990

Medical Records Phone: (239) 800-7412 or (239) 800-7441 / Fax: (239) 482-6297

Information to be disclosed: (initial all that apply):

Complete Health Record _____ Office Notes _____ Diagnostic Reports _____ Pap Smears _____
Laboratory Reports _____ Pathology Reports/Biopsies _____ Genetic Testing _____
Surgery Reports _____ HIV/AIDS testing _____ Psychological/Psychiatric Notes/Treatment _____
Substance Abuse Treatment _____ Other (please specify) _____

Please initial choice: _____ Fax Records _____Mail Records

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the Information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that this authorization is valid for up to six months from the date I sign it, unless I specify otherwise. I also understand that I may be charged for copies of my medical records as allowable under Florida Administrative Code Rule: 64BB-10.003. Further, I understand that I will not be denied or refused treatment if I refuse to sign this authorization.

_____ _____ _____
Signature of Patient or Legal Representative Date Relationship to Patient