PREMIER
WOMEN'S CARE
OF SOUTHWEST FLORIDA

Authorization for Release 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:

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 released to: _____
Note: if you are releasing records to yourself, please write SELF

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

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) _____

Reason for disclosure: (please circle):

Continuation of treatment Transfer of Care Legal Issue Insurance Change Personal Other

Please initial choice: _____ Fax Records _____Mail Records
Note: You or the entity will receive an invoice upon delivery of records with applicable pricing / fees.
Note: Due to security reasons associated with HIPAA regulations, e-mail is **NOT** available.

Medical Record Fee	in addition to medical record fee if records sent by: Mail (S&H fees may apply)	if: Electronic Delivery (medical offices / hospitals **ONLY**)
$1 per page up to 25	*In-state mail: $5*	*No Charge*
$0.25 per additional page	*Out-of-state mail: $10*	
	Out-of-country mail: $25	

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.

As described in the Notice of Privacy Practices of Premier Women's Care of Southwest Florida, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Premier Women's Care of Southwest Florida in reliance on this authorization, by sending a written revocation to Premier Women's Care of Southwest Florida, 9021 Park Royal Drive, Fort Myers, FL 33908 Attention: Medical Records.

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