# WOMEN'S HEALTHCARE PHYSICIANS OF NAPLES, LLC
# 775 First Avenue North, Naples, Florida 34102
# 11181 Health Park Blvd., Ste 2277, Naples, Florida 34110
# (239) 262-3399
# FAX (239) 261-1189

## AUTHORIZATION AND CONSENT TO OBTAIN INFORMATION FOR WOMEN'S HEALTHCARE PYSICIANS

TO: (physician or hospital)

_____

_____

_____

Patient Name: _____ Chart#: _____

Social Security# : _____ Birthdate: _____

**I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:**
**(PLEASE CHECK APPROPRIATE AREAS)**

( ) History and Physical Exam
( ) Discharge Summary (Date:_____)
( ) Insurance Verification/Determination
( ) Significant Other Evaluation
( ) Psychiatric/Psychological
( ) Other (please specify): _____

( ) Progress Notes
( ) Telephone Calls/Nurse & MD notes
( ) Laboratory Reports
( ) Report to Referral Source
( ) Operative Report (Date:_____)
( ) Correspondence (Specify):
_____

I hereby authorize release of the above information, including psychiatric, alcohol or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Women's Healthcare Physicians of Naples, and hereby release the above from all legal liability that may arise from the release of the information requested. If, in the judgment of the medical staff, disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of information to the program's insurance carrier when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed. I further understand that Women's Healthcare Physicians of Naples reserves the right to notify the above-named person, corporation or agency of my revocation in the event that I revoke this consent to release information.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____