Douglas E. Gearity, M.D., F.A.C.O.G & Associates

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth:____________________

Previous Name: _______________________________ SSN:__________________________

I, ____request and authorize the release of

medical records from ____________________________fax: _________________

to be release to:

The Women's Center of Orlando
3000 Hunter's Creek Blvd.
Orlando, FL 32837

This request and authorization applies to:
All previous Breast Images, Radiology Reports, Mammography CD

______________________ ________________________ _____________________
Patient Name Signature Date

3000 Hunter's Creek Blvd. · Orlando, FL 32837
Phone (407) 857-2502 · Fax (407) 857-1855
www.wcorlando.com