A New Life

OB/GYN of Broward

Experience Compassionate Care.

Jane E. Matos-Fraebel, M.D., F.A.C.O.G.

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: ______________________________ **Date of Birth:** ____/____/____

Address: ______________________________

City: ____________________ **State:** ____________ **Zip Code:** ____________

Last Four Digits of Social Security# ____________ **Telephone:** (______) ______ - ______

Please release information from / to: A New Life OB/GYN of Broward, LLC/ Jane E. Matos-Fraebel, MD FACOG

4850 W. Oakland Park Blvd Suite 118 Lauderdale Lakes, FL 33313

Phone: (954) 485-1511 Fax: (954) 739-7948

Doctor's information to be released from / to:

Office/Physician's Name: ______________________________

Address: ______________________________

City: ____________________ **State:** ____________ **Zip Code:** ____________

Telephone: (______) ______ - ______ **Fax:** (______) ______ - ______

Please Release:

- ○ Pap Smear Results
- ○ Ultrasound/Imaging Results
- ○ Bone Density (Dexa) Scan Result
- ○ Mammograms
- ○ Vitamin D Levels
- ○ Lab Results
- ○ Prenatal Records
- ○ All Medical Records
- ○ Other: ____________

Reason for release:

- ○ Transfer Of Care
- ○ Consult/Second Opinion
- ○ Moving
- ○ Self * There is a fee in the amount of $____________
- ○ Patient will pick up records

Revocation: **I understand that I may revoke this consent at any time and that the consent will automatically expire twelve (12) months from the date of the signature. I do not authorize further release to a third party. I understand that once information is released under this authorization, the office, it's employees and the physician(s) cannot prevent disclosure of this information.**

A reasonable copying charge is defined as $1.00 each for the first 25 copies and $0.25 each for every copy in excess of $25, Fla Admin. Code Ann. 64BB-10.003. Please note that if records are released to a new provider there will be no administrative fee.

Authorization**: I authorize the above provider to release the information marked above to the recipient.**

****I understand that it is ultimately my responsibility to retrieve my prior records.***

Signature of Patient/Guardian: ______________________ Date: ____/____/________

Relation to Patient if signed by Guardian: ______________________

Reason Patient unable to sign: ______________________

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