Authorization for Release of Medical Records

To: _____

_____

Phone no._____ Fax no. _____

I _____ hereby authorize to disclose information from my medical records, as well as other data pertinent to your treatment of me to:

Dr. Silpa Senchani, M.D, FACOG
Women's Health Specialists of Cetral Florida
3131 Innovation Dr. St. Cloud, FL 34769
Phone: (407) 498-0071 Fax: (407) 498-0073

Specific information to be released: _____

This information is needed for the following reason: _____

_____ _____
Print name Date of birth

_____ _____
Patient or Legal Guardian Signature Date

_____
Witness

This Medical Record may contain information about drug abuse, alcoholism, venereal disease, abortion, mental health treatment, HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be release.

__ I DO consent to have this information disclosed.

__ I DO NOT consent to have this information disclosed.

Signature:_____ Date:_____