Obstetrics & Gynecology Associates of Central Florida LLC

2400 North Orange Blossom Trail, Suite 300

Kissimmee, FL 34744

407-846-7200 Fax: 407-846-3989

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(AUTORIZACION PARA LA LIBERACION DE REGISTROS MEDICOS)

I _____, hereby authorize Obstetrics and Gynecology Associates of Central Florida, LLC to release or obtain medical, psychiatric, alcohol, and/or drug abuse, HIV testing ARC and/or AIDS diagnosis, eating disorder information or any medical records sensitive nature to:

(Check One) _____ **Obtain From** _____ **Release To**
(Obtener de) (Liberar a)

Name: _____
(Nombre)

Address: _____
(direccion)

Phone: _____
(Telefono)

Fax: _____

I would like for my records to be released in the form of:

_____ **Fax** _____ **Mail** _____ **Email** _____ **CD**

For the purpose of: (Example: Continued Care, Transfer Care, PCP or Personal Records)

_____

The specific records to be disclosed shall include: (Example: Lab Results, Reports, Pathology, etc.)

_____

Please specify the Date (s) of service for records or Specify ALL for complete chart:

_____

I understand that this consent is revocable upon written notice to the doctors, except to the extent that action that has already been taken on this authorization. This authorization shall remain in force until _____, or 90 days from the date written below to accomplist the purpose for which it is given. Alcohol and drug information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Transmission of medical records will have a fee of $1.00 per page for the first 25 pages, and $0.25 for each copy thereafter.

_____	_____	_____
Date of Birth	**Patient Signature**	**Date of Authorization**
(Fecha De Nacimiento)	(Firma de la Paciente)	(Fecha de autorizacion)