

Authorization for the Release of Confidential Information

Patient Name: _____		Date: _____
Date of Birth: _____		Social Security #: _____
Phone: _____		Previous Name(s): _____
Release To:	Brenda M. Barry, M.D. 930 Lake Baldwin Lane Orlando, Florida 32814	Phone #: (407) 898-1500 Fax #: (407) 898-3022
Release From:	Dr. Name: _____	
	Phone #: _____ Fax #: _____	
	Address: _____	
	City: _____	State: _____ Zip Code: _____

Information to be Released

<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> GYN Ultrasound Reports
<input type="checkbox"/> Pap Smear reports	<input type="checkbox"/> Bone Density Report
<input type="checkbox"/> STD test reports	<input type="checkbox"/> Biopsies and surgical reports
<input type="checkbox"/> Mammography reports	<input type="checkbox"/> All of the above
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Other: _____

May NOT include information related to:

<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Drug and/or Alcohol Abuse	<input type="checkbox"/> Genetic Counseling/Testing
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Reason for Release

<input type="checkbox"/> Copies for my Family Dr.	<input type="checkbox"/> Referred to another physician
<input type="checkbox"/> Consult/2nd Opinion	<input type="checkbox"/> Changing Gyn's
<input type="checkbox"/> Transferring for OB care	<input type="checkbox"/> Other (please explain): _____
<input type="checkbox"/> Moving out of area	

Expiration of Release

If I fail to specify an expiration event or condition, the authorization will expire in one year.

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

I authorize the provider listed above to release my medical information.

_____ Signature of Patient/Guardian	_____ Date
_____ Print Name (if not the patient)	_____ Relationship to patient if Guardian
_____ Signature of Witness	_____ Date

Your State Legislature determines the cost of records. Any payments are required prior to release.

ERROR: undefined
OFFENDING COMMAND:

STACK: