

Authorization for the Release of Confidential Information**WomenCare of Baldwin Park***A Healthy Woman is a Powerful Woman*

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Phone: _____ Previous Name(s): _____

Release To: Brenda M. Barry, M.D. Phone #: (407) 898-1500
 930 Lake Baldwin Lane Fax #: (407) 898-3022
 Orlando, Florida 32814

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"/> Mammography DVDs | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab Reports | |

May NOT include information related to:

-
- HIV/AIDS
-
- Mental Health
-
- Drug and/or Alcohol Abuse
-
- Genetic Counseling/Testing

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.