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

Release To: Dr. Name: _____

Phone #: _____ Fax #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to be Released

- ☐ Office Visit Notes
- ☐ Pap Smear reports
- ☐ STD test reports
- ☐ Mammography reports
- ☐ Mammography DVDs
- ☐ Lab Reports
- ☐ GYN Ultrasound Reports
- ☐ Bone Density Report
- ☐ Biopsies and surgical reports
- ☐ All of the above
- ☐ Other: _____

May NOT include information related to:

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

Reason for Release

- ☐ Copies for my Family Dr.
- ☐ Consult/2nd Opinion
- ☐ Transferring for OB care
- ☐ Moving out of area
- ☐ Referred to another physician
- ☐ Changing Gyn's
- ☐ Other (please explain): _____

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) Realtionship to patient if Guardian

_____ _____
Signature of Witness Date

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