Gentle Hands OB/GYN

Authorization for Release of Medical Information

Name _____ Date of Birth _____

Phone Number _____ Last 4 of SS# _____

I authorize the release of my medical information for the purpose of continuing medical care:

□ To □ From

Gentle Hands OBGYN
2391 Oak Myrtle Lane
Wesley Chapel, Florida 33544
Phone: 813-803-2219
Fax: 813-994-5539

□ From □ To (Name, Address, Phone and Fax Number)

_____

_____

Initial: ****DO NOT SEND ANY RECORDS ON A CD****

_____ All records
_____ All lab work
_____ Diagnostic Imaging (**no disc**)
_____ Psychiatric/Psychological information as protected by Florida Statute 456.057
_____ Drug/Alcohol information protected by Florida Statute 397.501
_____ HIV/AIDS information protected by Florida Statute 381.004(3)(f)
_____ Sexually transmitted diseases as protected by Florida Statute 384.29
_____ Prenatal records including lab work and sonograms
_____ Pap smear results
_____ Operative Report
_____ Discharge Summary Date _____

Information released may not be redisclosed without further authorization by the patients. This authorization will be valid for 180 days after the date of the patient's signature as it appears below.
You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent we have already used or disclosed this information in reliance on this authorization.
I understand I have the right to refuse this authorization and that with my signature all parties are released from any and all legal liability that may arise from the released information requested.

Signature of Patient _____ Date _____

If patient is a minor or unable to sign, title/legal status of empowered representative:

_____ Date _____