HIBISCUS
WOMEN'S CENTER

Authorization to Disclose Health Information

Patient Name: _____

DOB:_____SSN:_____Phone:_____

Address:_____

City:_____State: _____ Zip:_____

OBTAIN Medical Records From: (Doctors office, Hospital, Facility)

NAME:	
ADDRESS:	
CITY, STATE, ZIP:	FAX #:

PLEASE RELEASE MY RECORDS TO:

NAME:	HIBISCUS WOMEN'S CENTER	
ADDRESS:	330 EAST HIBISCUS BOULEVARD	
CITY, STATE, ZIP:	MELBOURNE, FL 32901	321-724-2229 (office) 321-728-6681 (fax)

I, _____, give authorization for your office to release the following information: (if applicable):

- ❑ OB Record
- ❑ History and Physical
- ❑ Progress Notes
- ☑ Annual WW Reports
- ❑ Operative Reports
- ❑ Physician Orders
- ❑ Discharge Summary
- ❑ Special Procedure(s) (please specify)_____
- ☑ Laboratory Test(s) (please specify) _Pap Smear _____
- Other (please specify)_____

If applicable, I also give permission for the following to be disclosed (please initial):
_____acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
_____behavioral health services/psychiatric care
_____treatment for alcohol and/or drug abuse

From (date): Only most recent report(s) To (date): Present

I understand that the release or transfer of the information specified to any person or entity not specified above is prohibited. I hereby release the originating office or facility, its employees, officers and physicians from any legal responsibility or liability that may arise from complying with this authorization. I understand that the medical record maintained by the doctor may contain medical and administrative information from other healthcare providers. I also understand that the doctor is authorized by Florida law to charge me for duplication costs incurred in connection with copying my medical records

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date _____. If I fail to specify an expiration date, this authorization will expire in twelve (12) months.

_____ _____

Signature of Patient or Legal Representative (Relationship) Date

_____ _____

Signature of Office Representative (Witness) Date