Naples OBGYN
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Naples, FL 34110
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: _____/_____/_____
First and Last Name *MM/DD/YYYY*

Phone: (____) ________________

Please check one of the following and include contact information as specified:

⏭ OBTAIN FROM: Name: **Naples OBGYN**
Address: **90 Cypress Way E, Suite 40, Naples, FL 34110**
Phone: **(239) 566-3000**
Fax: **(239) 566-7426**

⏭ RELEASE TO:
Name/Clinic/Provider: ______________________________
Address: ______________________________
____
Phone: (_____)______________________ Fax: (_____)________________

INFORMATION TO BE RELEASED (Please circle Yes or No for EACH category listed):		
Y N Medical History	Y N Operative Reports	Y N HIV/AIDS Record
Y N Treatments and Tests	Y N Laboratory Reports	Y N Prenatal/OB Records
Y N Pathology Reports	Y N Hospital Records	Y N Ultrasounds
Y N Social History	Y N Medication Records	Y N Other___________________
Y N Mental Health Records	Y N Substance Abuse Record	______________________________
Y N Sexual History	Y N Consultations	______________________________
Y N Venereal Disease Record	Y N X-Ray Reports	______________________________

The information is needed for the following purpose(s): ______________________________
(examples include continuity of care, 2nd opinion, etc)

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I understand that these records are of a privileged and confidential status. I waive that status for the purpose contained within this authorization. I agree to hold Naples OBGYN harmless from any and all cost, liability, and damages of any nature whatsoever, including attorney fees resulting directly or indirectly from Naples OBGYN release of these records pursuant to this consent. This authorization will automatically expire (90) days following the date of signature without my expressed revocation. I understand that there will be a fee for receiving hard copies of my records:**$1 USD per page for the first 20 pages, then $0.25 per page for any additional pages thereafter.**

I acknowledge that I have read and understand this authorization and its content.

______________________________ ______________________________
Signature of Patient (must be 18yrs +) Date   Relation to patient if signed by guardian Date

______________________________ ______________________________
Witness Date   Reason patient unable to sign (ex."minor")

Prohibition of re-disclosure. The information is being disclosed to you from records whose confidentiality is protected by state law. Specifically Florida Statutes 395.3025, 455.667 and 394.459. State Laws prohibit you from any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A general authorization is not sufficient for this purpose.

Completed by: ______________________ FAX PICK UP MAIL Date Completed:____/____/____
staff member *MM/DD/YYYY*