Azalea Women's Healthcare

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Adrienne George, M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
(Last) (First) (Middle) (Maiden)

Patient's Address_____City_____State_____Zip_____

Date of Birth _____ Ph. #'s_____

PERSON OR ENTITY TO **RELEASE** INFORMATION:	PERSON OR ENTITY TO **RECEIVE** INFORMATION:
Name_____	Name_____
Address_____	Address_____
City_____State_____Zip_____	City_____State_____Zip_____
Phone_____Fax_____	Phone_____Fax_____

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

- ☐ Complete Medical Record
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Mammogram Reports
- ☐ Pap Smear/ Biopsy Reports
- ☐ Billing Records
- ☐ Ultrasound Reports
- ☐ Surgery Records
- ☐ Obstetrical (OB) Records
- ☐ Other (specify) _____

FEE FOR COPIES:

For Personal Use:
$1.00 per page up to 25 pages. Over 25 pages,
$0.25 cents per page (According to Florida Law)

For Continuing Care:
No Charge (when we fax or mail)

This authorization will expire on _____ (If no date specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

☐ **I DO** ☐ **I DO NOT** authorize the release of information pertaining to specific laboratory test of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such test, the diagnosis of *Acquired Immune Deficiency Syndrome* (AIDS) or AIDS related conditions, and all medical records and clinical information relating thereto.
Initials of individual authorization: _____

☐ **I DO** ☐ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and information pertaining to any evaluation, treatment and/or hospitalization for *mental health* or *psychiatric* conditions.
Initials of individual authorization: _____

☐ **I DO** ☐ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and information pertaining to any evaluation, treatment and/or hospitalization for *drug* or *alcohol use, drug related and/or alcohol related treatment.*
Initials of individual authorization: _____

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. The use of disclosure of the Information identified above is voluntary and I need not sign this form to ensure health care treatment, I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization, Releaser and its agents and employees are hereby authorized to obtain, Inspect and reproduce such records and/or Information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____/_____/_____

Signature of Patient or Patient's Representative Date