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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: ______________________ PHONE: ______________________

D.O.B. ______________________ Last 4 digits of Social Security Number: ______________

THIS IS TO AUTHORIZE any physician, hospital, medical attendant, or other health care provider to furnish

TO: Name/Facility/Practice: ______________________

Address: ______________________

____

Phone # ______________ Fax# ______________

FROM: Name/Facility/Practice: ______________________

Address: ______________________

____

Phone # ______________ Fax# ______________

REASON FOR REQUEST: ______________________

I HEREBY AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS AS REQUESTED ABOVE:

- ☐ All general medical records ______________
- ☐ Office Visits ______________
- ☐ Lab Results ______________
- ☐ Copy of Medical Images (Procedure/Date of Exam) ______________
- ☐ Radiologist Interpretation of Medical Images ______________
- ☐ Only release/Other (Please specify) ______________

☐ This information will include mention of or testing of drug abuse, alcohol abuse, psychiatric records, HIV testing and/or AIDS.

☐ Exclude mention of:

- ☐ HIV and/or AIDS
- ☐ STD
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Psychiatric Records
- ☐ Sexual Assault Records

I have carefully read this consent, understand its contents and consent to the release of the above-specified information. I understand that this authorization may be revoked at any time by written notification; however, it will not have any affect on any actions Sekine, Rasner & Brock LLC took before they received the revocation notice. This information is for the person/facility to which it is addressed to only. The confidentiality of this information is protected by Federal Law.

COST FOR RELEASE OF MEDICAL RECORDS: To another OB/GYN physician outside the local area – no charge, records will be provided as a courtesy. To OB/GYN physicians within the local area, to insurance companies for attending physician statement; attorney's office; and patients: $1.00 per page up to 25 pages; $ .25 per each additional page; and current cost of certified mail/return receipt. A $20 deposit may be required for such services. Florida Administrative Code 64B8-10.003

Signed: ______________________ Date: ______________
(Patient, Parent or Guardian)

Patient Name (Please print): ______________________ DOB: ______________

Witness: ______________________

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.