

**OBSTETRICS AND GYNECOLOGY ASSOCIATES  
A Division Of Women's Care Florida**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS  
FROM OBSTETRICS & GYNECOLOGY ASSOC.**

(Patient Name)	(Date of Birth)	(Social Security #)
(Complete Address)	(Phone)	

<b>THE INFORMATION IS TO BE RELEASED BY:</b>	<b>AND IS TO BE PROVIDED TO:</b>
Name of Facility OB/GYN ASSOCIATES	Name of Facility
Facility Where You Were Last Seen: <b>MARK ONLY ONE</b> <input type="checkbox"/> 116 Parsons Park Drive • Brandon, Fl. 33511 (813) 681-6625 • Fax (813) 699-1032 <input type="checkbox"/> 125A N Moon Avenue • Brandon, Fl. 33510 (813) 643-6690 • Fax (813) 643-6930 <input type="checkbox"/> 13149 Elk Mountain Drive • Riverview, Fl. 33579 (813) 675-8326 • Fax (813) 675-8336 <input type="checkbox"/> 1503 W. Reynolds Street • Plant City, Fl. 33563 (813) 752-4103 • Fax (813) 759-6166	Street Address
	City, State and Zip Code
	Phone # and Fax, if possible

**THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD:**

All Medical Information and Reports

**OR ONLY:**

Other (please specify): \_\_\_\_\_

**REASON FOR RECORDS (Please mark all that apply):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> TRANSFER OF CARE  | <input type="checkbox"/> PERSONAL RECORDS        | <input type="checkbox"/> FMLA/DISABILITY   |
| <input type="checkbox"/> SECOND OPINION    | <input type="checkbox"/> FOR PRIMARY CARE DOCTOR | <input type="checkbox"/> INSURANCE REQUEST |
| <input type="checkbox"/> FINANCIAL REASONS | <input type="checkbox"/> MOVING OUT OF AREA      | <input type="checkbox"/> WORKERS COMP.     |

**OTHER REASON:** \_\_\_\_\_

*I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of signature. I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the healthcare provider or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law. I further understand and acknowledge that I am responsible for all costs associated with the provision of the information.*

Cost: \_\_\_\_\_ \$1.00 per page up to 25 pages and .25 cents there after  
 \_\_\_\_\_ Mammogram films: \$35.00 CD \_\_\_\_\_ \$5.00 per image

\_\_\_\_\_  
 Signature of Patient or Person Legally Authorized to Consent for Patient Date

\_\_\_\_\_  
 Relationship to Patient (if applicable)

A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL