

ADVANCED WOMEN'S HEALTH SPECIALISTS

John V. Parker, MD
David L. Goss, MD
Edmund C.A. Boulting, MD, FACOG
Nateya D. Carrington, MD

Donna Balo, CNM, ARNP, MS Alyssa Belt, CNM, ARNP, MSN Carmon Carlson, CNM, ARNP, MSN Brooke Dean, CNM, ARNP, MSN Michelle Senig, CNM, ARNP, MSN Donna Andries, ARNP-BC Andrea Lilavois, WHNP-BC Cynthia Lopez, FNP-BC Alicia Gamble McLoone, PA-C Linda G. New, PA-C

MEDICAL RECORD RELEASE REQUEST

Date:					
I,				_authorize Advanced Women's Health Specialists to:	
	□ Release	□ Obtain	□ Trans	nsfer Out of Practice	
REASON:					
Approximate	dates of requested	information:			
This informat	ion may include psy	rchological, drug rel	ated, HIV test	sting, AIDS or AIDS related records.	
AUTHORIZA I understand					
 I may revol I may refus If the requested be disclose If I do not s I understant 	e to sign this authorize estor or receiver is not ed. sign this form, my heal	t any time in writing, bi ation and that is strictly a health plan or health th care and the payme obtain a copy of the in	y voluntary. h care provider, ent for my healtl	not affect any actions taken prior to receiving the revocation. r, the released information may no longer by federal Privacy regulations and may lith care will not be affected. cribed on this form, for a reasonable copy fee, if I ask for it.	
Patient/Guardian/Representative Signature			Date:		
Patient/Guardian/Representative Printed Name			Relationship to Patient		
Witness Signature			Date:		
Patients Nam	ne:				
Date of Birth: Social Securi				cial Security #:	
	There will be a pre \$0.25 cents thereat		ant to the Flor	orida Administrative Code 21m-26.003) of \$1.00 per page for the first	
Information Requested From:				Send Information To:	
Name/Company:				Name/Company:	
Address:				email:	
Phone#		Fax#		Phone# Fax#	