ADVANCED WOMEN'S HEALTH SPECIALISTS

AdvancedWomens.com

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MEDICAL RECORD RELEASE REQUEST

Date: _____

I, _____ authorize Advanced Women's Health Specialists to:

☐ Release ☐ Obtain ☐ Transfer Out of Practice

REASON: _____

_____

Approximate dates of requested information: _____

_____

This information may include psychological, drug related, HIV testing, AIDS or AIDS related records.

AUTHORIZATION:
I understand that:

1. This authorization will remain in effect for 30 days.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer by federal Privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form after I sign it.

_____ _____
Patient/Guardian/Representative Signature Date:

_____ _____
Patient/Guardian/Representative Printed Name Relationship to Patient

_____ _____
Witness Signature Date:

Patients Name: _____

Date of Birth: _____ Social Security #: _____

Please Note: There will be a prepayment fee (pursuant to the Florida Administrative Code 21m-26.003) of $1.00 per page for the first 25 pages and $0.25 cents thereafter.

Information Requested From:	**Send Information To:**
Name/Company:	Name/Company:
Address:	email:
Phone# Fax#	Phone# Fax#

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Lake Mary, FL 32746
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809 Douglas Avenue
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