AUTHORIZATION TO RELEASE INFORMATION

Sending Records to Another Physician/Facility

Patients Name: _____
(Last) (First)

Date of Birth: _____ Social Security No. _____

Address: _____
(Street) (City) (State/Zip)

Home Phone: _____ Work Phone: _____

I authorize South Lake Women's Health to release medical information from my medical records and send it to:

New Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I authorize you to release my entire records to the physician named above subject to the following limitations, if any:

_____No Limitations (including HIV testing, if applicable) _____Lab(s)/Pathology

_____Radiology _____Operative Reports

_____Other than listed above (Please be specific) _____

_____

Reason for request: _____

This authorization will expire thirty (30) days from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our office, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Termination date: _____

I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand there will be a records copying fee for the information that I am requesting.

Signature: _____ Date: _____

For office use only

Received by/date _____ Payment received _____ Mail/Picked up/Interoffice: _____

Physicians Authorization _____

Fees for copy of records: $20 labor fee (includes first 10 pages)
then $.50 (per pages 11 through 50) and $.25 (per pages 51 or higher)
Mailing Costs: $10 rush fee if records are to be provided within two business days
$20 certifying fee (if certified)
Another Medical Facility: FREE