U FIRST HEALTH • SURGERY & GYNECOLOGY
12640 World Plaza Lane • Bldg. #71 • Fort Myers, FL 33907
Phone: 239.243.8222 Fax: 239.206.4779

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ **Date of Birth** _____
Social Security Number _____
I authorize the following provider, or entity to disclose certain protected health care information pertaining to me:

Physician's Name: _____

Address: _____

Phone # _____ **Fax #** _____

Information to be released to: _____U FIRST HEALTH • SURGERY & GYNECOLOGY_____

Physician Requesting Records: _____

Phone # _____239.243.8222_____ **Fax #** _____239.206.4779_____

Information to be disclosed:

_____ Complete Health Records _____ Specific Dates of Service _____ Specific Conditions

I understand that this WILL NOT include the following information unless indicated and initialed below.

_____ Initials _____ Aids or HIV Infection
_____ Initials _____ Behavioral Health Care/Mental Health Services
_____ Initials _____ Sexually Transmitted Disease Information
_____ Initials _____ Treatment for Alcohol and/or Drug Abuse

This information is to be disclosed for the purpose of _____
Are you leaving the practice? _____ YES _____ NO
Reason for transfer of records _____
_____

I understand that this Release is valid up to six (6) months from the date I sign it. When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may not longer be protected under the Federal HIPAA Rule. I may revoke this Authorization at anytime, except to the extent that the practice has acted in reliance upon this Authorization. My revocation must be submitted in writing to the Site Supervisor, at the address listed above.

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Relationship to Patient**