AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Please read and complete thoroughly. **Return to our office by Fax to 239-449-2444**. Medical records cannot be released/obtained until this form is completed and signed by the patient or legal guardian. May take up to 30 days to process.

1

PATIENTS NAME: ____ DATE OF BIRTH: _____________
Last First Initial

MAIDEN NAME: ____ SOCIAL SECURITY NUMBER: _______________

ADDRESS: ____
Street City State Zip

PHONE NUMBER: (_________)____________________________________

WILL YOU BE RETURNING TO A WOMAN'S PLACE FOR FUTURE CARE? { } YES { } NO

2

I HEREBY AUTHORIZE A WOMAN'S PLACE, FORMERLY NAPLES OB/GYN AND DR. STEPHEN THOMPSON, TO SEND RECORDS TO:

____
Facility or Physician's name

____
Facility or Physician's address

____
Telephone # Fax # Attention to:

IF YOU ARE LEAVING THE PRACTICE AND TRANSFERRING TO ANOTHER PHYSICAN, PLEASE TAKE A MOMENT TO TELL US WHY YOU ARE LEAVING: { } Moving from area { } Change of Insurance { } Unhappy with service { } Unhappy with quality of care

3

I WISH TO RELEASE/OBTAIN THE FOLLOWING MEDICAL INFORMATION:

{ } Last Year { } Last 3 Years (Recommended)
{ } Physical exams/history { } Pap results { } Other______________________________
{ } Blood work results { } X-Ray/mammogram/ultrasound reports

I understand that treatment and coverage is not based upon my signing this authorization. This information is needed for:

{ } To provide ongoing treatment/aftercare. { } At the request of the patient (or parent/legal guardian
{ } Other ____

4

I understand this authorization is subject to revocation at any time unless action based on it has already begun. Requests for revocation will be done in writing. The authorization expires 90 days from the date of signature. I understand that the information may be subje ct to re-disclosure by the recipient and may no longer be protected by federal or state law. I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release of information is done substantially in accordance with the applicable law. Authorization does not include psychotherapy notes, information protected under Fed. Reg. 42 CFR Part II or HIV information unless authorized.

{ } I DO { } I DO NOT agree that a copy of this form is valid as the original.

Date: _______________________ Signature of patient____

Signature of legal guardian or parent of patient under 18 ___________________________________/_______________
Relationship to patient

1660 Medical Blvd. Suite 100 | 1660 Medical Blvd. Suite 300 | 90 Cypress Way E Suite 40

Naples, FL 34110 Phone (239)513-0053 Fax: (239)449-2444 www.awpnaples.com