Authorization for Release of Medical Records

Legal Name: ____ SS# ______/_______/______

Phone Number: (_____)_________________________________ Date of Birth: _______________________

I am the Surrogate/Designee and hereby authorize release of information from:

(Your records with WGNF going to another doctor)

WGNF Records to Dr. ________________________

Phone: ____________________________________

Fax: _______________________________________

Address: ___________________________________

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(Your records from another doctor coming to WGNF)

Records from Dr. ____________________________

Phone: ____________________________________

Fax: _______________________________________

To: **Women's Group of North Florida**

6440 W Newberry Road, Suite 508

Gainesville, FL 32605; Phone: (352) 792-6123

Fax: (352) 792-6138

The following records are requested: (Please select all that apply)

_______ Pap Smear Results

_______ Prenatal/OB Record

_______ Imaging Results: _______________________

_______ Lab Results: ____________________________

_______ GYN Operative Report: __________________

_______ Other: ________________________________

I understand that this authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.

I understand that this authorization will remain in effect for (1) year or until I revoke it in writing.

I hereby release Women's Group of North Florida and its employees from any and all liability that may arise from the release of information as I have directed.

_______________________________________ Patient's Signature

_______________________________ Date

____ Witness