AUTHORIZATION FOR RELEASE FOR MEDICAL RECORDS

Patient's Name_____

Address_____

DOB_____ **SS#**_____

Dates of Service_____**Purpose of Request**_____

I AUTHORIZED THE RELEASE OF RECORDS, INCLUDING THOSE WHICH MAY CONTAIN CONFIDENTIAL HIV/AIDS RELATED INFORMATION, (INCLUDING TESTING, DIAGNOSIS OR TREATMENT0, CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, RELATION TO MENTAL HEALTH AND/OR ALCHOL/DRUG USE, AND THE CARE AND TREATMENT THEREOF.

___History and Physical
___Discharge Summary
___Operative Report
___Pathology Report
___Laboratory Report
___C-Section Operative Report
___EKG Report
___X-Ray/Ultrasound Reports
___Other (please specify)

I HEREBY AUTHORIZE _____
(Physician, Healthcare Facility)

_____
(City, State, Zip Code)

_____
(Telephone) (Fax)

TO RELEASE ALL OF THE ABOVE REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

Sunlife OB/GYN Services
4101 NW 4th Street
Suite 306
Plantation, FL 33317
954.625.2229 fax 954.625.2301

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken, I understand that every attempt at confidentiality will be made. This authorization and request is fully understood by me and is made voluntarily on my part.

_____
Signature of Patient, Legal Guardian or Authorized Representative) (Date)

(Relationship to Patient)