

Please read and complete thoroughly. **Return by Fax to <u>239-449-2444</u>**. 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. For printed records, an administrative fee may be charged. Please ask office staff.

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

		3 3
	PATIENT NAME:	DATE OF BIRTH:
1	Last First Initial	
	MAIDEN NAME:	SOCIAL SECURITY NUMBER:
	ADDRESS:Street City	State Zip
	DUONE NUMBER.	
	PHONE NUMBER: ()	
	WILL YOU BE RETURNING TO A WOMAN'S PLACE FOR FUTURE CARE?	
	I HEREBY AUTHORIZE A WOMAN'S PLACE TO	{ } OBTAIN FROM: { } RELEASE TO:
2		
	Facility or Physician's name	
	Facility or Physician's address	
	racinty of Physician's address	
	Telephone # Fax #	Attention to:
	IF YOU ARE LEAVING THE PRACTICE AND TRANSFERRING TO ANOTHER	R PHYSICAN, PLEASE TAKE A MOMENT TO TELL US WHY:
	{ } Moving from area { } Change of Insurance { } Unhappy with service { } Unhappy with quality of care	
	I WISH TO RELEASE/OBTAIN THE FOLLOWING MEDICAL INFORMATION	N FROM:
	{ } Last Year { } Last 3 Years (Recommended) { } Physical exams/history { } Pap results	{ } Entire medical history
3		{ } Hospital records eports { } Other
	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 t	the patient (or parent/legal guardian)
	{ } Other	
	I understand this authorization is subject to revocation at any time unless action writing. The authorization expires 90 days from the date of signature. Lundersta	, , ,
4	writing. The authorization expires 90 days from the date of signature. I understand that the information may be subject 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	
	Signature of legal guardian or parent of patient under 18	Polationship to national

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