Florida Perinatal Center, LLC.
Maternal Fetal Medicine
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RECORD RELEASE

I understand that, under Florida Law, the classification of records checked above relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me or my personal representative or otherwise provided by Florida law.

Patient Name: _____ / _____
Last First Middle Initial Maiden

Address: _____
Street City State Zip Code

Birth date: ____ /_____ /_____ Telephone: (_____) _____ Social Security Number: _____

I, _____, authorize _____
Patient / Personal Representative Name (please circle) Name of Facility
to release my health information indicated below to the following party (check one): MYSELF ____ OTHER____
Name of Facility: _____ Tel: _____ Fax: _____
Address:_____
Street City State Zip Code
For the Purpose of: _____
I authorize release of information covering treatment dates of: _____.
The type and amount of information to be disclosed is a follows (include dates where appropriate):
_____ Entire Medical Record, excluding: _____
_____ Consultations
_____ Physician Progress Notes
_____ Laboratory Reports
_____ Ultrasound Reports
_____ Other, describe _____

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation o the Medical Records Department.
_____ (initial) I understand that authorization for the disclosure of this health information is voluntary; I can refuse to sign, and The Florida Perinatal Center, LLC. will not base my treatment, payment, or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with reasonable charge).
_____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by the Federal Confidentiality Laws or The Florida Perinatal Center, LLC.
_____ (initial) I understand that The Florida Perinatal Center, LLC. will release only the minimum amount of information necessary to fulfill a request.
Unless otherwise revoked, this authorization will expire six months from the date of the signature listed below.

_____ _____ _____ /_____ /_____
Patient/Personal Representative Signature Print Name Date
_____ _____ _____ /_____ /_____
Witness Print Name Date