Institute for Women's Health and Body
Obstetrics, Gynecology

☐ **1395 State Road 7, Suite 450**
Wellington, Fl 33414
Phone: (561) 798-1233
Fax: (561) 472-1772

☐ **560 Village Blvd, Suite 315**
West Palm Beach, Fl 33409
Phone: (561) 616-9988
Fax: (561) 616-0507

☐ **8188 Jog Rd. Suite 203**
Boynton Beach, Fl 33437
Phone: (561) 740-1911
Fax: (561)740-1856

☐ **4495 Military Trl Ste 101**
Jupiter, Fl 33458
Phone: (561) 799-3722
Fax: (561) 799-3692

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____ SS#_____

Patient's Phone Number: _____ Date of Request: _____ **Date needed:** _____

***(NOTE:** Under HIPAA Privacy Rule request for records may take up to 30 days)*

☐ **Check here** **OR** ☐ **Check here**

I authorize the Institute for Women's Health and Body **to RELEASE my medical records to**:

_____
Name of Provider or Facility

_____
Address, City, State, Zip Code

_____
Phone# Fax# (include area code)

I authorize the Institute for Women's Health and Body **to OBTAIN my medical records from**:

_____
Name of Provider or Facility

_____
Address, City, State, Zip Code

_____
Phone# Fax# (include area code)

PURPOSE FOR THIS REQUEST: *Transferring Care___ *Insurance/Payment Issues___ *Personal __ *Other___ *Relocation____

TYPE OF RECORDS REQUESTED: *Entire Records___ *Obstetrical Records___ *Surgical Records___ *Lab Results (type) _____ *Other_____

Unless otherwise stated, I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that:
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Pursuant to HIPPA Privacy Rule: Your provider is allowed to charge you a fee for the requested records. The charges are $1.00 per page up to 25 pages, then $.25 every page after that.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): _____

Witness: _____ Date: _____