AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date **of Birth**: _____

Phone: _____

Please Note: Charges for personal use are $1 per page for the first 25 pages and 50¢ for each additional page.

PLEASE SELECT ONE OF THE FOLLOWING:

☐ I authorize Seasons Women's Care to **RELEASE** my medical records to:

Provider/Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

☐ I authorize Seasons Women's Care to **OBTAIN** medical records from:

Provider/Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

RESTRICTIONS: Only medical records originated through Seasons Women's Care will be copied unless otherwise requested. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The purpose of disclosure is ☐Transfer of Care ☐Second Opinion ☐Referral ☐Other _____

Type of records requested: ☐Entire records ☐Other (specify) _____

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative Date

Please Fax Records to: ___(561) 328-6091 ___(561) 318-7106 ___(561) 530-3838 ___(888) 987-6762

Andrea Bayer, MD, FACOG • Sarah Knowlton, MD, FACOG • Jessica Clark, MD, FACOG • Katherine Gonzalez, MD • Karen Bradshaw, ARNP

10115 Forest Hill Blvd., Suite 300 & 310 Wellington, FL 33414 Office Phone: 561-328-6165