THE
WOMAN'S
GROUP

Obstetrics, Gynecology, Infertility, & Menopause

EXCELLENCE IN WOMEN'S HEALTHCARE

AUTHORIZATION TO RELEASE, RECEIVE, OR EXCHANGE INFORMATION

Patient's Name: _____

DOB: _____ SSN: _____

I authorize The Woman's Group to:

EXCHANGE, RECEIVE AND/OR RELEASE TO ME AND/OR ANY PHYSICIAN OR OTHER HEALTHCARE PROVIDER ALL NECESSARY MEDICAL RECORDS NEEDED FOR ONGOING HEALTHCARE.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this agreement is voluntary. I understand that if the requesting organization is not a health plan or health care provider; the release information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of one year from the date of authorization and may be revoked at any time via written notice by me, except to the extent that the information has already been released through compliance with this authorization.

I understand that I may revoke this authorization at any time by notifying The Woman's Group in writing, but if I do, it won't have any effect on any actions taken prior to receipt of my notice of revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific authorization of the undersigned, or as otherwise regulated.

_____

Signature of Patient/Legal Representative

_____

Date

5380 Primrose Lake Circle • Tampa, FL 33647 • Telephone (813) 769-2778 • Fax (813) 769-2779
2716 W. Virginia Avenue • Tampa, FL 33607 • Telephone (813) 875-8032 • Fax (813) 875-0227
3815 Atmore Grove Drive • Lutz, FL 33548 • (813) 428-7030 • Fax (813) 428-7040
13005 S. US Hwy. 301 • Riverview, FL 33578 • Telephone (813) 915-5291 • Fax (813) 915-5293
www.thewomansgrouptampa.com

(Rev. 11/17)