AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient's Name: _____ Birthdate: _____

Social Security #: _____ Other Name Used: _____

Address: _____ City, State, Zip: _____

Dates of Services: _____ Purpose of Request: _____

I authorize the release of records, including those which may contain confidential *HIV/AIDS* related information, (including testing, diagnosis or treatment), confidential communicable disease related information, relating to mental health and/or *ALCOHOL/DRUG USE*, and the care and treatment thereof.

☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Pathology Report
☐ Laboratory Reports
☐ EKG Reports
☐ C-Section Operative Report
☐ X-Ray / Ultrasound

I hereby authorize _____
(Physician, Healthcare Facility)

_____
(Address)

_____
(City, State)

_____
(Telephone) (Fax)

TO RELEASE ALL OF THE ABOVE REQUESTED MEDICAL RECORDS TO:

PREMIERE PERINATAL ASSOCIATES, PA
CONSULTATIVE & DIAGNOSTIC CENTER FOR HIGH RISK OBSTETRICS
500 SE 17TH STREET, SUITE 100
FT. LAUDERDALE, FL 33316
TELEPHONE: (954) 468-3080 ~ FAX: (954) 468-3082

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS AUTHORIZATION HAS ALREADY BEEN TAKEN. I UNDERSTAND THAT EVERY ATTEMPT AT CONFIDENTIALITY WILL BE MADE. THIS AUTHORIZATION AND REQUEST IS FULLY UNDERSTOOD BY ME AND IS MADE VOLUNTARILY ON MY PART.

_____
SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

_____ _____
(RELATIONSHIP TO PATIENT) DATE