

# Celebration Obstetrics & Gynecology Associates, P.A.

410 Celebration Place, Suite 208, Celebration, Florida 34747

2209 North Boulevard, Suite C, Davenport, Florida 33837

Phone: 407-566-2229 Fax: 407-566-2499

## AUTHORIZATION TO REQUEST or RELEASE HEALTH INFORMATION

1. I, \_\_\_\_\_, I hereby authorize **Celebration Obstetrics and Gynecology** to

Request records from

Release records to

Business Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

2. The following type of medical information: (list dates and tests if specifics needed)

\*Lab Results: \_\_\_\_\_

\*Image Results: \_\_\_\_\_

\*Immunizations: \_\_\_\_\_

\*Entire Record: \_\_\_\_\_

3. By indicating "Entire Record" all medical information, information regarding any sexually transmitted disease, psychiatric treatment, drug and/or alcohol abuse, HIV testing, ARC and/or AIDS information in my records will be released. *If you prefer certain medical information not be released, please contact the appropriate office staff.*

4. This information for which I am authorizing disclosure will be used for the following purpose:

\*Second Opinion \_\_\_\_\_ \*Relocation \_\_\_\_\_ \*Transfer of Care \_\_\_\_\_ \*Other \_\_\_\_\_

Reason for Request: \_\_\_\_\_

5. **This authorization will expire on:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

6. If I fail to specify a date, this authorization will expire in 6 months from the date it was signed.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization in writing, the revocation will not apply to information that has already been released.

8. I understand that once the information has been disclosed, the recipient may re-disclose it and federal privacy laws may not protect the information.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date