Celebration Obstetrics and Gynecology

410 Celebration Place, Ste 208
Celebration, Florida 34747

Fax 407-566-2499

2209 North Boulevard West Ste C
Davenport, Florida 33837

Fax 407-566-2499

AUTHORIZATION TO REQUEST HEALTH INFORMATION

1. I, ___________________________, hereby authorize **Celebration Obstetrics and Gynecology** to
   Print Name

request information from: Name:____________________________ Phone:_________________________

Fax:________________________ Address:____

2. The following type of medical information: (List dates and tests if specifics needed)
   *Lab Results:____
   *Image Results:____
   *Entire Record:____

3. By indicating "Entire Record" all medical information, pregnancy related information, gynecological 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 office staff.*

4. This information for which I am authorizing disclosure will be used for the following purpose: *Second Opinion_______ *Relocation_______ *Other_______

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 above information is disclosed, the recipient may re-disclose it and federal privacy laws may not protect the information.

____
Signature of Patient of Authorized Representative

_________-__________-_________
Date of Birth

_________-__________-_________
Date

____
Witness