Port Orange Gynecology
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO YOUR OTHER DOCTORS

I,_____, date of birth_____, hereby authorize Port Orange Gynecology to release copies of my medical records for my continued healthcare care.

Send information to:

Doctor Name/Practice	
Address	
Phone Number	
Fax Number	

There will be no charge to send records directly to the above location as long as this location is a healthcare provider. I understand if I choose to have a copy of my records for myself, there will be a charge of $1.00 per page up to the first 100 pages and $.25 cents for each page thereafter.

I authorize and understand that all records may include Labs, X---rays, Consult notes, Progress notes, Emergency Department notes, Hospital Records (Sensitive information may include HIV results/treatment, Psychiatric and Drug Abuse) will be released to the above facility.

As required by state and federal law, your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I hereby release Port Orange Gynecology and its employees from any and all liability that may arise from the release of information as I have directed.

Patient Signature:_____Date: _____

Signature of Parent/Guardian:_____Date: _____

Relationship to Patient _____