Lakeland Premier Women's Clinic

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Authorization for Release of Medical Information

(Copying Charges: $20 for pages one (1) through twenty (20); $1 per page for the next eighty (80) pages; 50 cents for each additional page for personal use, insurance and attorneys)

I hereby authorize and request records to be released for:

Patient's Name: ________________________________ Other names seen under:______________________________________

Patient's Address:____

Phone #:__________________________ Social Security #:_________________________ Date of Birth:__________________

Chart #:________________ Records Requested for date(s) of________________________to ____________________________

Records to Be Received From:

____

Address/City, State & Zip

____

Phone/Fax

____

Records to Be Sent To:

____

Address/City, State & Zip

____

Phone/Fax

____

Authorization applies to the following information: (Check all applicable) ____________________________

□ Office Notes □ Lab Reports □ Radiology Reports □ OP Reports
□ Hospital Notes □ Complete

Purpose of Release: (Check Applicable Reason)
□ Consult (2nd Opinion) □ Seeking New Physician □ Relocation □Referral

Expiration Notice: I understand that this authorization shall expire when processing is completed.

I understand the following:
a. I have the right to revoke this authorization in writing at any time, except to the extent information has been release in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

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Signature of Person Authorized **Date**
(Specify legal authorization if signing in a representative capacity, e.g., Patient, Parent or Legal Guardian)