FLORIDA WOMAN CARE OF INDIAN RIVER COUNTY, LLC

James J. Presley, M.D., F.A.C.O.G. Marian A. Sampson, M.D., F.A.C.O.G.
Patricia S. White, A.R.N.P.
1000 – 37th Place, Suite 105
Vero Beach, Florida 32960
Phone: 772-562-2402 Fax: 772-562-5842

Authorization for Release of Medical Records/Information

_____
Last Name First Name MI

_____
Address City State Zip code

Birth Date _____/_____/_____ SS# _____-_____-_____

Purpose of Release: _____release to primary care physician _____insurance purposes
_____transfer to new Ob/Gyn _____legal purposes
_____release for personal use _____moving

I hereby authorize Florida Woman Care of Indian River County, LLC to:

_____ **Obtain** my records from:
_____ **Release** my records to:

Person or organization _____
Street Address _____
City/State/Zip _____
Phone (_____)_____ Fax (_____)_____

I release and hold harmless Florida Woman Care of Indian River County, LLC, James J. Presley, M.D., Marian A. Sampson, M.D. and/or Patricia White, A.R.N.P., physicians' practice and staff from any and all liability that may arise from complying with this authorization. I understand that the medical records may contain sensitive information regarding use of alcohol, drugs, tobacco, medications, AIDS/HIV testing and results, sexually transmitted diseases, psychiatric care, etc. Section 456.057(4) and (13), Florida Statutes, Rule 64B-9,003(3), Florida Administrative Code.

I am requesting that my entire medical record be release to the person/organization named above including records of:
HIV/AIDS _____ ("yes" or "no")
STD (sexually transmitted diseases) _____("yes" or "no")
Drug/alcohol abuse information/treatment _____("yes" or "no")
Psychological/psychiatric information/treatment _____("yes" or "no")
Records from other physicians _____ ("yes" or "no")
Records NOT to be copied _____

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Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until _____ but shall not exceed beyond two (2) years of the date below in accordance with state insurance and privacy laws regulation and I further understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulation found under 45 C.F.R. & 164.524). I further understand that in accordance with federal law that I have the right to review my medical records and to seek amendment or supplement to said records.

By signing this form, I am granting consent to Florida Woman Care of Indian River County, LLC to use and disclose my protected health information for the purposes of payment, treatment, health care operations and health oversight. The Florida Woman Care of Indian River County, LLC Notice of Privacy Practices provides more detailed information about how they may use and disclose this protected health information. I understand that I have a legal right to review the Notice of Privacy Practices before I sign this consent and Florida Woman Care of Indian River County, LLC encouraged me to read it in full and that I received a copy of the Notice of Privacy Practices.

I understand that doctors offices are authorized by Florida law to charge me for costs incurred in connection with duplication of medical records. This fee is set at $1.00 per page for the first 25 pages and then 25 cents for each additional page (rule 59R-10.003 of the Florida Administrative Code). This fee is due at the time of authorization.

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received _____ Yes _____ No

_____ _____
Patient Signature Date

_____ _____
or Parent/Legal Guardian Date

_____ _____
Request Received by Date