Woman's Health Centers
Any Woman. Any Time.

MFM of Central FL | MATERNAL FETAL MEDICINE CLINIC OF CENTRAL FLORIDA

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Release of Information Form

Patient Name: _____ **Date:** _____
Address: _____ **SSN:** _____
_____ **DOB:** _____

Receive Records FROM:

Name: _____
Phone: _____
Fax: _____

Release Records TO:

_____
_____
_____

Please send a copy of my medical records as indicated for any date(s) of treatment on file:

- ☐ Operative Reports
- ☐ Lab Results
- ☐ Discharge Summary
- ☐ Prenatal Records
- ☐ History & Physical
- ☐ Radiology Reports
- ☐ Other _____

Purpose of releasing medical information:

☐ **I authorize the release of my STD/HIV/AIDS testing to the person(s) listed above.**

☐ **I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.**

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment of alcohol or drug-related medical problems. This special consent also will apply to HIV/AIDS, related diagnoses, sexually transmitted infections/diseases, and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part II) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom the information pertains to, unless otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____ _____
Signature of Patient/Legal Guardian **Date** **Witness**