Joseph F. Lang, M.D, FACOGS
12250 East Tamiami Trail, Suite 210, Naples, FL 34113
239-389-5264 Fax 239-389-5260

PATIENT AUTHORIZATION

I hereby authorize ☐ Island OB/GYN ☐ ______________________________
Name of Facility and Address

to disclose the following information from the health records of:

Patient Name ______________________________ Date of Birth ______________
Address ______________________________ City ______________ State ________ Zip Code ____________
Email Address ______________________________ Telephone No. ______________________

Date(s) of Service ______________________

Information to be disclosed: * Included in Abstract

☐ Abstract
☐ Office Visit Notes*
☐ Laboratory Results *
☐ Imaging * (MRI, Ultrasound, CT, X-Ray)
☐ Other (please specify) ______________________
____

I understand that this will include information relating to (check if applicable)

☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
☐ Behavioral Health Services/ Psychiatric Care
☐ Treatment for alcohol and/or drug abuse

This information is to be disclosed to:

☐ Self ☐ Island OB/GYN ☐ ______________________________
Name of Doctor/ Hospital/Insurance Company/Other Agency, Person

Address: ______________________________
(If other than Self or Island OB/GYN) Tel: ______________________ Fax: ______________________

For the Purpose of:

☐ Continuation of Care
☐ Social Security/ Disability
☐ Legal Purposes
☐ Insurance Purposes
☐ Personal Access
☐ Other: ______________________

- Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.
- I understand that Island OB/GYN may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I also understand that this consent may be revoked by me at any time by submitting a written revocation notice.
- I understand that if this form is submitted electronically to Island OB/GYN, there is no guarantee of secure transmission until it is received by Island OB/GYN

I understand that my authorization will remain effective until the end of the calendar year.

Patient's Signature ______________________________ Date ______________

The above individual is unable to consent/sign because (check one):

☐ Minor ☐ Incompetent ☐ Other (explain): ______________________________

______________________________ Authorized Representative Signature
______________________ Date
______________________ Relationship

OFFICE USE ONLY:	DATE COMPLETED: / /	COMPLETED BY:	PAGES SENT/PRINTED:	PRINTED FAXED E-FAXED