Joseph F. Lang, M.D, FACOGS
983 N. Collier Blvd Marco Island, FL 34145
T: 239-389-5264 F: 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