Memorial Medical Center
2919 West Swann Ave, Suite 307
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Reproductive Health Associates
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900 Carillon Parkway, Suite 301
St. Petersburg, FL. 33716

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name (print name): ____

Date of Birth: _____/_____/_______ Social Security Number: ________________ Telephone Number: ____

Patient Address: ____

I hereby request that my medical records described below be (please circle) **released to / obtained from:**

Physician's Name: ____

Address: ____

Telephone Number: ______________________________________ Fax Number: ____

( ) *Disclose records to patient stated above for personal use*.

( ) ALL MY RECORDS
( ) SPECIFIC RECORDS INCLUDING: ____

Include the following: (indicate by initialing):

____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse.
____ Sexually transmitted disease records.
____ Genetics.
____ Records of HIV testing and/or AIDS diagnosis or treatment.
____ Psychiatric, psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness.

I understand the failure to initial the above five items, indicates that I do not want those specific records released.

I also understand the following:

- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting the Privacy Officer at (813) 872-0018.
- Reproductive Health Associates reserves the right to charge $1 per page fee for copying of medical records up to twenty-five pages, and $0.25 per page thereafter. If a fee is to be assessed, the patient will be informed of the total cost before medical record copies are made.
- My health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.
- I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for Reproductive Health Associates to inform the requester that portions of the record have been withheld.
- I understand that written notification is necessary to cancel this authorization.
- I understand that Reproductive Health Associates has the right to take up to ten businesses days for the evaluation and collection of patient records before release.

Patient Name (please print): ____Signature of Patient: _______________________________________

Date____________________ Expiration Date: This authorization if effective until the following date: _____________________or 90 days from the date signed

Method of Disclosure:

_____ Mail to above Patient address _____ Picked up by Patient _____ Mail to above Provider _____ Fax to above Provider