



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD**

**PURPOSE OF DISCLOSURE:**

Continuing medical treatment    Residence Relocation    Second Opinion    Patient Request

**For purposes other than Treatment, Payment and Operations:  
(Patient is to receive a copy of the Authorization)**

Research    Disability Insurance    FMLA    Life Insurance

Marketing Promotion: I have been informed **North Florida OB/GYN** \_\_\_\_\_ is \_\_\_\_\_ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

Other (please specify): \_\_\_\_\_

I understand that this authorization will expire **one year** from the date of signature below.

**RIGHT TO REVOKE AUTHORIZATION:**

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. I HEREBY RELEASE **NORTH FLORIDA OB/GYN** FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

**AUTHORIZATION & SIGNATURE:**

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **North Florida OB/GYN** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities:* 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. *For other entities:* up to \$1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Social Security #: \_\_\_\_\_

Printed Name of Parent, Guardian or Legal Representative: \_\_\_\_\_

**Parent, Guardian or Legal Representative Signature:** \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ **Records are needed by:** \_\_\_\_\_ (date)

Send by:  Fax \_\_\_\_\_ (Patient must initial approval)    Mail    Patient will pick up    Electronic format, if EMR