Gynecologic Specialists of Brevard
8043 Spyglass Hill Rd, Suite 101 - Melbourne, FL 32940
Office: (321) 265-5116 Fax (844) 375-3148

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____ Social Security Number: _____

Patient Address: _____

I hereby authorize (physician's name):_____

To disclose records obtained in the course of my evaluation and/or treatment to:

Dr. Janie Geraci - OR - Dr. Samuel Del Rio

Disclosure will include: (check all that apply) ☐ ALL record information Dates:_____

☐ History & Physical ☐ Lab Reports ☐ Operative Reports ☐ Radiology Reports

☐ Progress/Physician Notes ☐ Pathology Reports ☐ Other: _____

Please initial on each line below to include these specific records in this release. **I understand that failure to initial the three (3) items below, indicates that I do not want or authorize those specific records released.**

_____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.

_____ Records related to HIV testing and results and/or AIDS diagnosis or treatment, and/or STIs.

_____ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, tests, social work assessment, medications, psychiatric examination, progress notes, consultations, and/or treatment plans.

_____ Records related to Genetic testing and results

I also understand the following:

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 my health care provider to inform the requester that portions of the record have been withheld.

- This authorization shall remain valid unless revoked and will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee the recipient will not redisclose my health information to a third party not subject to applicable federal and state law governing the use and disclosure of my health information.
- I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility for benefits.

_____ _____
Signature of Patient or Substitute Decision Maker Date

_____ _____
If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

REASON FOR REQUEST:

_____ Moving out of State
_____ No Insurance
_____ New Patient
_____ Personal Records
_____ Transferring Care

REASON: Continuation of Care

METHOD OF DISCLOSURE:

_____ Mail to above patient address _____ Hand delivered to patient
_____ Mail to above provider _____ Faxed to above provider
_____ Electronic Transfer

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HAND DELIVERED RECORDS

_____ _____
SIGNATURE DATE

Signature of Completer: _____

Date_____