PHYSICIANS TO WOMEN, P.A.
TELEPHONE: 772-288-2992 FAX: 772-288-2999
EMAIL: RECORDS@PTWFL.COM
1815 S. KANNER HWY-STUART, FL. **1945 SE PORT ST. LUCIE BLVD-PORT ST. LUCIE,FL**
1304 N. LAWNWOOD CIRCLE - FT. PIERCE, FL **1000 37TH PLACE, SUITE 105- VERO BEACH, FL**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME IN FULL:_____

DATE OF BIRTH:_____ LAST 4 DIGITS OF SS NUMBER_____

PHYSICIAN NAME:_____DATE OF SERVICE:_____
ADDRESS: _____
TELEPHONE:_____

I _____, hereby request and authorize the release of the following records:

_____ Copy of Complete Medical record
_____ Emergency Room Report
_____ Surgery Reports
_____ Radiology Reports/Imaging
_____ Pathology Reports
Laboratory Test Results _____
Chart Notes Only_____
Obstetrical Records_____
Previous C-Section/VBAC reports_____
Other_____

***CHARGES MAY APPLY FOR COPYING RECORDS OR PROVIDING RECORDS IN ACCORDANCE AND IN COMPLIANCE WITH FLORIDA LAW.**
My records may contain the following information:
UNLESS CROSSED OUT, I SPECIFICALLY AUTHORIZE THEM TO BE RELEASED:
_____HIV TEST RESULTS (Test for AIDS)
_____AIDS related records
_____Psychiatric, mental or emotional records
_____Drug or alcohol records

RELEASE TO:

_____
NAME MAILING ADDRESS

_____
CITY STATE ZIP TELEPHONE/FAX

FOR THE PURPOSE OF CONTINUITY OF CARE UNLESS OTHERWISE STATED_____

Pursuant to Florida law, the record may be used only for the purpose provided and to whom requested. Any information may not be re-disclosed to any other person with the specific written consent of the undersigned. I understand I may revoke this consent at any time before the information has been released. This consent expires in 6 months unless another date is written here:_____. Physicians To Women, PA is hereby released from any responsibility for maintaining confidentiality of information released to me or parties designated by me in this aurthorization, such release being made in good faith.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE:_____/_____
DATE

RELATIONSHIP TO PATIENT_____ WITNESS: _____