Full Circle Women's Care

6871 Belfort Oaks Place, Jacksonville, FL 32216

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Social Security Number: __ __ __-__ __-__ __ __ __ Phone: (____) _____

I authorize Full Circle Women's Care, an Obstetrics and Gynecology practice with contact numbers:
Office: (904) 674-0022 **Fax: (904) 425-0192**

Please check one of the following and include contact information as specified:

⏭ OBTAIN FROM: Name _____
Address _____
_____
Phone (_____)_____
Fax (_____)_____

⏭ RELEASE TO: Name _____**Full Circle Women's Care**_____
Address _____**6871 Belfort Oaks Place**_____
_____**Jacksonville, FL 32216**_____
Phone (_**904**_) **674-0022**_____
Fax (_**904**_) **425-0192**_____

INFORMATION TO BE RELEASED (Please circle Yes or No for each category listed):		
Y N Medical History	Y N Operative Reports	Y N HIV/AIDS Record
Y N Treatments and Tests	Y N Laboratory Reports	Y N Prenatal Records
Y N Pathology Reports	Y N Hospital Records	Y N Ultrasounds
Y N Social History	Y N Medication Records	Y N Other_____
Y N Mental Health Records	Y N Substance Abuse Record	_____
Y N Sexual History	Y N Consultations	_____
Y N Venereal Disease Record	Y N X-Ray Reports	_____

The information is needed for the following purpose(s): Continuity of care or _____
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I understand that these records are of a privileged and confidential status. I waive that status for the purpose contained within this authorization. I agree to hold Full Circle Women's Care harmless from any and all cost, liability, and damages of any nature whatsoever, including attorney fees resulting directly or indirectly from Full Circle Women's Care release of these records pursuant to this consent. This authorization will automatically expire (90) days following the date of signature without my expressed revocation. I understand that there will be a fee for receiving hard copies of my records: $1 USD per page for the first 20 pages, then $0.25 per page for any additional pages thereafter.

I acknowledge that I have read and understand this authorization and its content.

_____ _____
Signature of Patient (must be 18yrs +) Date Relation to patient if signed by guardian Date

_____ _____
Witness Date Reason patient unable to sign (ex."minor")

Prohibition of re-disclosure. The information is being disclosed to you from records whose confidentiality is protected by state law. Specifically Florida Statutes 395.3025, 455.667 and 394.459. State Laws prohibit you from any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A general authorization is not sufficient for this purpose.

Sent by: _____ FAX PICK UP MAIL Date Completed:____/____/20____