

Celebration Obstetrics and Gynecology

410 Celebration Place, Ste 208
Celebration, Florida 34747

2209 North Boulevard West Ste C
Davenport, Florida 33837

Fax 407-566-2499

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AUTHORIZATION TO REQUEST HEALTH INFORMATION

1. I, _____, hereby authorize **Celebration Obstetrics and Gynecology** to
Print Name

request information from: Name: _____ Phone: _____

Fax: _____ Address: _____

2. The following type of medical information: (List dates and tests if specifics needed)

*Lab Results: _____

*Image Results: _____

*Entire Record: _____

3. By indicating "Entire Record" all medical information, pregnancy related information, gynecological information, information regarding any sexually transmitted disease, psychiatric treatment, drug and/or alcohol abuse, HIV testing, ARC and/or AIDS information in my records will be released. *If you prefer certain medical information not be released, please contact office staff.*

4. This information for which I am authorizing disclosure will be used for the following purpose: *Second Opinion _____ *Relocation _____ *Other _____

5. This authorization will expire on _____ - _____ - _____.

6. If I fail to specify a date this authorization will expire in 6 months from the date it was signed.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization in writing, the revocation will not apply to information that has already been released.

8. I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws may not protect the information.

Signature of Patient of Authorized Representative

_____-_____-_____
Date of Birth

_____-_____-_____
Date

Witness