AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION

The Woman's Group
2716 W. Virginia Avenue
Tampa, FL 33607
(813) 875-8032
FAX: (813) 875-0227

The Woman's Group
3000 Medical Park Drive Suite 300
Tampa, FL 33613
(813) 769-2778
FAX: (813) 769-2779

The Woman's Group
1908 Land O' Lakes Boulevard
Lutz, FL 33549
(813) 428-7030
FAX: (813) 428-7040

Patient Name: _____

Address: _____

Date of Birth: _____Social Security Number: _____

I hereby request and authorize:

_____
Name of healthcare facility

_____
Address

_____
City State Zip

_____
Phone Fax

To release to:

_____
Name of person or facility requesting information

_____
Address

_____
City State Zip

_____
Phone Fax

The foregoing is subject to such limitations as indicated below:

( ) 1. Confined to records regarding admission and treatment for the following medical condition:
_____

( ) 2. Covering records for the period from _____to _____

( ) 3. NO LIMITATIONS placed on dates, history or illness or diagnostic and therapeutic information including any treatment for alcohol and drug abuse as protected by federal regulation 42CFR part II, psychiatric/psychological information and AIDS related information including testing, FS 490.32 and/or 90.503, 381.609.

This authorization will expire 180 days from the date signed.

_____
Patient Signature Date