HER GYN
women's care by a woman

681 Douglas Ave Ste 109, Altamonte Springs Fl, 32714

Medical Records Release

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

Social Security #: XXX-XX-_____ Phone: (_____) _____-_____ ☐Home ☐Cell

I authorize: _____
(Doctor or Facility we are receiving records from)

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

To release the following information:

☐All Records ☐Lab/pathology records ☐X-rays / radiology reports
☐Billing Records ☐Abstract / Summary ☐Pharmacy / prescriptions records
☐Other: _____

To the following medical facility:

HER GYN ,LLC

681 Douglas Ave ste 109, Altamonte Springs Fl, 32714
Phone: (321)462-5050 ~ Fax: (321) 972-6885

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164 524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the Federal confidentiality rules. Any re-disclosure of this information be recipient is not protected under this authorization. This authorization shall remain valid for six (6) months from the date signed below.

Signed: _____ Date: _____
☐Patient or Authorized Person ☐Parent ☐Legal Guardian ☐Executor ☐Power of Attorney ☐Other: _____

Witness: _____ Date: _____