SHIVAKUMAR HANUBAL, M.D., F.A.C.O.G.
NATALIA ALEJANDRO, M.D., F.A.C.O.G.
NELLY RIVERA, M.D.
SHAWN LUNDBERG, APRN
TAMICHA GOODEN, APRN

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ____ **Date of Birth:**_______________________

(Please Print)

Phone #: ____ **S.S.** __________________________________

Practice/Provider Name: ____

Address: ____

Phone: ____ **Fax:** __________________________________

To **Release** my protected health information, including copies of the medical record of the above-named patient to the **following facility:**

ADVANCED OBSTETRICS & GYNECOLOGY OF LAKE COUNTY, LLC
1414 East Main Street Leesburg, FL 34748
Phone (352)728-3898 **Fax (352) 728-6240**

Information to be released

____ Entire Medical Record & Reports
____ Diagnostic Tests
____ Prenatal Records
____ Include Drug/Alcohol treatment information (initial here) _______
____ Radiology Reports & Images
____ Include Behavioral/Mental information (initial here) _______
____ Pathology Reports & Specimens
____ Include HIV-related information (initial here) _______
____ Lab Results
____ All of the above with the exception of ________________
____ Other: (specify) ____

Expiration Date: This authorization will expire twelve (12) months from the date which it was signed unless otherwise specified: ___________ (date of expiration)

Redisclosure: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realized that treatment, payment, enrollment in a health plan, or eligibility of benefits will not be conditioned upon my authorization of this disclosure.

Revocation: I understand I may revoke this authorization anytime by writing a letter and presenting my revocation to the medical records department. I understand that the revocation will not apply to information that has been already released in response to my authorization.

____ _______________________

Patient or Authorized Representative *Date*

____ _______________________

Print Name *Relationship with Patient*