Premiere
Obstetrics & Gynecology

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date: _____

I HEREBY REQUEST AND GIVE AUTHORITY TO PREMIERE OB/GYN TO OBTAIN A COPY OF MY MEDICAL RECORD FROM:

Physician/Hospital/Other: _____

Address: _____

_____

Fax: _____ Phone: _____

I HEREBY REQUEST A COPY OF MY MEDICAL RECORD BE RELEASED TO:

Premiere Ob/Gyn
1150 N. 35th Avenue, Suite 405
Hollywood, Florida 33021
Phone: (954) 961-9993 / Fax: (954) 961-0163

PATIENT TO DESIGNATE RECORD(S) TO BE RELEASED:

_____
Patient Signature

I agree that any and all medical information may be released, including but not limited to mental health, drug or alcohol use, HIV/AIDS test results and other records protected by state and federal laws.

_____
Patient Signature

I request that the release of medical information be restricted to the following portions of my medical record:

_____
_____
_____

I understand that this authorization is valid for 60 days from the date of my signature.

_____ Date: _____
Patient or Parent/Legal Guardian Signature

_____ Date: _____
Witness

Memorial Regional
1150 N. 35th Ave., Ste. 405
Hollywood, FL 33021
(954) 961-9993 • Fax (954) 961-0163

Memorial West
601 N. Flamingo Rd., Ste. 401
Pembroke Pines, FL 33028
(954) 961-9993

Premiere
Obstetrics & Gynecology

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

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Physician/Hospital/Other: _____

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