



Obstetrics & Gynecology  
 8950 SW 74 Court, Suite 2001  
 Miami, FL 33156

Phone: 305-661-7766 Fax: 305-661-0329

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. 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.

You have my permission to leave a detailed message or via email:

Tel. \_\_\_\_\_ Email: \_\_\_\_\_

I authorized this office to discuss my medical care with the following persons/organization:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

The patient or patient's representative must read and initial the following statements:

Initials

1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If you fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insured with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

\_\_\_\_\_  
 Signature of Patient or Legal Representative

\_\_\_\_\_  
 Date

***This document will be retained by the providing organization for six years.***

Modified 6/10/16