

**South Florida Women's Care
Obstetrics and Gynecology**

8950 SW 74th Ct, Suite 2001
Miami, FL 33156
Office 305-661-7760
Fax 305-661-7769



**Lucia Gaitan, MD, FACOG
Ester Averro, PA-C**

AUTHORIZATION TO DISCLOSE PHI

I, _____ (Patient Name), with DOB of ____/____/____ give permission to South Florida Women's Care to share the information marked below on Section I of this document with the person(s) or organization(s) I have specified in Section II of this document.

Section I.

I would like to give permission to receive my medical record as specified below;

- ☐ Disclose my complete health record
- ☐ Disclose my complete health record except
 - ☐ Mental Health Records
 - ☐ Communicable diseases including but not limited to HIV and AIDS
 - ☐ Alcohol/Durg abuse treatment records
 - ☐ Genetic information

Section II.

I would like to give permission to person/organization listed below:

I understand that the person/organization listed above may no be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

This authorization to share my information is valid until I supply the office with written cancelation to South Florida Women's Care at 8950 SW 74 Ct, Suite 2001, Miami, FL 33156.

I understand that:

In the event my information ahs already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

I do not need to give any further permission for the information detailed in section I to be shared with the person/organization listed in Section II.

Failure to sign/submit this authorization or cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information it is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services rendered.

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If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete section below.

Name: _____

Describe how this person has legal authority to sign form:

Signature: _____

Date: _____

Patient signature and date below:

Patient / Guardian or Legal Representative Signature

Date

Printed Patient / Guardian or Legal Representative Name

DOB