TRINITY UROGYNECOLOGY

WESLEY CHAPEL UROGYNECOLOGY

MEDICAL RECORDS RELEASE

Patient Name:_____ Date of Birth: _____

Address: _____

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health, or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders of mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. I understand this authorization will expire one year from the date signed unless otherwise specified: _____ (enter expiration date)

_____ _____

Signature or Personal Representative **Date**

FOR OFFICE STAFF:

Release my medical records to:

Trinity Urogynecology / Wesley Chapel Urogynecology

2202 Duck Slough Blvd, Suite 102 New Port
Richey FL 34655
Ph:727-203-5073,Fax:727-205-4493

From: _____ Phone/Fax number: _____

The Specific information to be disclosed is:

[ ] Physician's chart notes
[ ] Operative Reports
[ ] Imaging reports (CT scan, ultrasound)
[ ] Urological related records
[ ] Gynecologic related records
[ ] Pathology reports
[ ] Other _____