

**U FIRST HEALTH • SURGERY & GYNECOLOGY**  
12640 World Plaza Lane • Bldg. #71 • Fort Myers, FL 33907  
Phone: 239.243.8222 Fax: 239.206.4779

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

I authorize the following provider, or entity to disclose certain protected health care information pertaining to me:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Information to be released to: U FIRST HEALTH • SURGERY & GYNECOLOGY

Physician Requesting Records: \_\_\_\_\_

Phone # 239.243.8222 Fax # 239.206.4779

**Information to be disclosed:**

\_\_\_\_\_ Complete Health Records \_\_\_\_\_ Specific Dates of Service \_\_\_\_\_ Specific Conditions

I understand that this WILL NOT include the following information unless indicated and initialed below.

\_\_\_\_\_ Initials \_\_\_\_\_ Aids or HIV Infection  
\_\_\_\_\_ Initials \_\_\_\_\_ Behavioral Health Care/Mental Health Services  
\_\_\_\_\_ Initials \_\_\_\_\_ Sexually Transmitted Disease Information  
\_\_\_\_\_ Initials \_\_\_\_\_ Treatment for Alcohol and/or Drug Abuse

This information is to be disclosed for the purpose of \_\_\_\_\_

Are you leaving the practice? \_\_\_\_\_ YES \_\_\_\_\_ NO

Reason for transfer of records \_\_\_\_\_

I understand that this Release is valid up to six (6) months from the date I sign it. When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may not longer be protected under the Federal HIPAA Rule. I may revoke this Authorization at anytime, except to the extent that the practice has acted in reliance upon this Authorization. My revocation must be submitted in writing to the Site Supervisor, at the address listed above.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

