north florida Women's Care
OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*The undersigned authorizes **North Florida Women's Care** to release my health information as noted below.*
1401 Centerville Rd, Suite 202 ▪ Tallahassee, FL 32308
Ph. 850-877-7241 ▪ Fx. 850-877-1338

*Patient Information *Please Print**

Patient Full Name: _____ **Date of Birth:** _____ **Other Names?** _____

Patient Address: _____ **Phone #:** _____ **SS#** (last 4 digits)_____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Doctor completing form

Doctor: _____

Where do you want the form to be sent after completion?

Name : _____ **Attention:** _____

Email address: _____

Your record/form(s) will be provided as an Adobe PDF file on BACTES Mail Express portal. If your records/forms are not retrieved within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email.

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other: _____

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please complete the attached form for FMLA/disability leave. I authorize the release of supporting medical records to supplement my leave claim.

☐ I am requesting leave starting: _____
(1st day of Leave)

☐ I am requesting intermittent leave.
Reason: _____
Frequency: _____ times per ☐ week ☐ month

Medical Records Copies:
BACTES has set a cap of $25.00 plus postage (if applicable).

FMLA/Disability Forms Completion:
A fee of $30.00 *per form* is due at the time of submission. Updates are completed at no cost, up to 90 days after signature.

Records being sent to another healthcare provider will be sent at **no** cost. Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Florida State law Statute: 64B8-10.003

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial)*

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration, this authorization will expire in 1 year.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*