NAPLES WOMEN'S CENTER

A HealthLynked Company

Obstetrics Gynecology Infertility

www.napleswomenscenter.com

☐ **Patricia Elliott, MD, FACOG** ☐ **Cynthia Troy, ARNP**

☐ **Charles Adamcyzk,MD,FACOG** ☐ **Deanna Hobby, ARNP**

Patricia Elliott, M.D., F.A.C.O.G.

Carolyn Monaco, D.O., F.A.C.O.G.

Cindy Troy, A.N.R.P.

Deanna Hobby, ARNP

Authorization for Release of Medical Records from Other Provider

I, _____ on _____

Patient name Date

Hereby Authorize Release of My Medical Records

FROM: _____

_____

Phone: _____ Fax: _____

To release my medical records consisting of:

_____

From dates: _____ to _____

To: Naples Women's Center, LLC
1265 Creekside Pkwy, Suite 200
Naples, FL. 34108
Phone (239) 513-1992 Fax (239) 513-9022

For the purpose of:

__transferring locally __transfer out of town/state __copy to self***
__copy to family doctor/specialist __insurance company request

Naples Office

1265 Creekside Pkwy

Suite 200

Naples, Florida 34108

Ph.: 239-513-1992

Fax: 239-513-9022

I hereby authorize release of the above information, including psychiatric, alcohol or other drug dependency history of treatment, and HIV/AIDS antibody testing results, and /or from Naples Women's Center, and hereby release the above from all legal liability that may arise from the release of the information requested. If, in the judgement of the medical staff, disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation, or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of information to the program's insurance carriers when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above stated purpose, this consent will automatically expire one year from the date signed. Unless you specify a different date here: _____. I further understand that Naples Women's Center reserves the right to notify the above named person, corporation, or agency of my revocation in the event that I revoke this consent to release information.

Patient Signature: _____

DOB: _____ Social Security #_____

Last 4 digits

There is a processing time period of 3 to 5 business days on all records including transferring patient records, physician requests, patient copies, etc…