RELEASE OF INFORMATION

Authorization for Disclosure of Health Information
(As defined by HIPAA, a separate authorization must be used for psychotherapy notes.)

Patient Name: _____ Date of Birth: _____

I authorize **Omni Medical Center for Women**, to release my records or information relating to my health care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information to be Released:

[ ] Entire Medical Record
[ ] Medical History, Examination
[ ] Surgical Reports
[ ] Treatment or Tests
[ ] Hospital Records
[ ] Allergy Records
[ ] Immunizations
[ ] Prescriptions
[ ] X-ray Reports
[ ] Billing & Payment Information
[ ] Consultations
[ ] Laboratory Reports

[ ] Other (Specify)_____
[ ] Only for the Following Dates _____

We have no control over the person(s) you have listed as your personal representative(s). Therefore, your PHI disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of **Omni Medical Center for Women**.

Disclosure of Protected Health Information Via Alternative Means

I consent to receive calls from ***Omni Medical Center for Women***, regarding my protected healthcare and other services at the phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated notification system.

[ ] Home [ ] Cell [ ] Work

These authorizations will remain in effect until terminated by the patient, the patient's personal representative, or another individual legally authorized to do so by court order. The patient has the right to revoke or terminate these authorizations by submitting a written request to: **Omni Medical Center for Women, 706 W Platt St, Tampa, FL, 33606**

Patient Signature: _____ Date _____

Witness Signature: _____ Date _____