Bela Vida
Urogynecology

PO BOX 402
Gotha Fl 34734-0402
Phone (407) 982.4852

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

First Name	Last Name	DOB

Address	City	State	Zip
		FL	

By signing this form, I authorize BELA VIDA UROGYNECOLOGY to use, release or obtain the protected health information described below

☐ OBTAIN FROM / ☑ DISCLOSURE TO	☐ DISCLOSURE TO / ☑ OBTAIN FROM
Provider: _____ Address: _____ Phone: _____ Fax: _____	**Bela Vida Urogynecology** **PO Box 402** **Gotha, FL 34734-0402** **Please email this completed form to:** **forms@belavidaurogynecology.com**

INFORMATION TO BE DISCLOSED/OBTAINED:

☐ All medical records related to (specify ☐ Diagnostic imaging report: _____
☑ Most recent office notes / labs ☐ Pathology report reports: _____
☐ Specific records/information as follows: _____

PURPOSE: ☐ Personal ☐ Disability ☐ Insurance ☐ Legal Review X Continuing Care ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

I do X I do not ☐ authorize this information to be released

EXPIRATION: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date signed.

SIGNATURE OF PATIENT / LEGAL REP: X _____ **DATE:** _____

Relationship (if other than patient): _____

Name of individual signing on behalf of patient: _____