Florida Fertility Institute
Authorization for Release of Medical Information

Mark Sanchez, MD Yissa Fonticiella, MD Deborah Martin, APRN

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Home/Cell Phone #: _____

I hereby authorize the release of my medical information: **Please do not send discs and mail records in excess of 50 pages**

□ From: Florida Fertility Institute

□ To: Florida Fertility Institute
2454 N. McMullen Booth Road, Ste 601
Clearwater, FL 33759
Phone (727) 796-7705/ Fax (727) 796-8764

To: _____
_____
_____
Phone#_____

From: _____
_____
_____
Phone# _____

You may disclose the following Medical Information: □ Complete Medical Records □ Surgical Reports
□ Progress Notes □ Laboratory Reports □ Radiology Reports □ Other _____

The following items **will not** be released **without** my authorization. I authorize the disclosure of:

□ HIV/AIDS information as protected by Florida Statute 381.004(3)(f). Patient Initials: _____
□ Psychiatric/Psychological information as protected by Florida Statute 456.057. Patient Initials: _____
□ Drug/Alcohol abuse information as protected by Florida Statute 397.501. Patient Initials: _____
□ Sexually transmitted disease information as protected by Florida Statute 381.29 Patient Initials: _____

This authorization will be valid for 180 days after the date of the patient's signature as it appears below.

Florida Fertility Institute reserves the right to charge a fee for copying of medical records in accordance with Florida law. There will be a fee of $1.00 per page for the first 25 pages and 25¢ per page thereafter.

PATIENT RIGHTS: I understand that I do not have to sign this authorization in order to receive health care services. However, I do have to sign an authorization form when the purpose is to provide my medical information to a third party.

I understand that I have the right to revoke this authorization at any time, provided that I do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

I understand that once my medical information has been disclosed to the named person/organization listed in this authorization, Privacy laws may no longer protect it, and the named person/organization may re-disclose it.

_____ Date: _____
Signature of Patient

If the patient is a minor or unable to sign, title/legal status of empowered representative:

_____ Date: _____