

PROGRESSIVE WOMEN'S HEALTH, P.A.
MICHAEL J. COYLE, D.O.
6072 Doctor's Park Road
MILTON, FLORIDA 32570
Office-850-983-3528 Fax-850-983-3546

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of
Birth _____
Address _____
Date _____

I hereby request and authorize (Physicians
name) _____

(both numbers necessary) ph: _____
fax: _____

to release to Progressive Women's Health, P.A. the medical record
of _____
as more specifically provided below.

I understand and acknowledge that certain information which may be contained in the medical record requires specific disclosure, and except otherwise provided by law, such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information includes information pertaining to (1) treatment for mental and emotional conditions, (2) alcohol/drug abuse or HIV testing or test results.

I hereby authorize the release of information indicated below to the person named above for the purpose of continuity of care.

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

- () Laboratory results
- () Op report (s)
- () Discharge summary
- () Pathology reports
- () Doctors progress notes
- () Ultrasound (s)
- () Pap Smear results
- () Other _____

By signing below, the patient acknowledges their understanding that FAX transmissions may not be secure and privacy cannot be guaranteed. Nevertheless, permission is granted for transmission of the records by FAX or mail. The undersigned and the patient authorize and request copy or FAX signature to be accepted as original. This authorization will expire 60 days.

PLEASE FAX _____ PLEASE MAIL _____

Signature of Patient or Authorized Representative _____

Print Name _____

Relationship to Patient _____