Susan Fox, D.O.
F.A.C.O.O.G.

Natalya Medrano, M.D.
F.A.C.O.G

Dr. SUSAN FOX'S
center for women

Office: (305) 595-6488

**Susan Fox,** DO, FACOOG
**Laura Briz,** ARNP
**Natalya Medrano,** MD, FACOG

Fax: (305) 595-3532

# MEDICAL RELEASE FORM

I undersigned and authorize you to release my Medical Records to Dr. Susan Fox's Center for Women acknowledged that this Medical Records may contain documentation of a nature to include HIV or Aids related conditions or psychiatric information.

## PATIENT INFORMATION:

Full Name: ______________________________________

Date of Birth: _________/___________/______________

Social Security: _________-_________-_______________

Phone: ___________-____________-__________________

## INFORMATION TO BE REQUESTED FROM

Name: _________________________________________

Address: ________________________________________

Phone: __________-____________-__________________

Fax: ____________-_____________-__________________

## PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Legal Purpose ☐ Health Care ☐ Insurance Purpose

☐ Other: ____________________________________________________________________________

## CHECK THE APPROPRIATE BOX(S) FOR TYPE OF INFORMATION TO BE RELEASED:

☐ Consult ☐ Discharge Summary ☐ Lab Report ☐ Verbal release info

☐ Historical/Physical ☐ EKG ☐ Progress Notes ☐ Outpatient Reports

☐ Radiology Reports ☐ Pathology Report ☐ HIV Results ☐ All Records

☐ Other: ______________________________________________________________________________

I have been informed that there may be benefits or disadvantages to releasing this information. This authorization shall be valid for 90 days from the date of signature or from the date of completion of treatment whichever is later, unless otherwise expressly revoked by me in writing prior to that time. I understand that your policy requires payment of $1.00 per page copying fee Medical Records. If the records are mailed to a physician or another medical facility, there will be a copying fee charged. We required a minimum of 72 hrs. to process any requests.

Patient Signature: ____________________________

Legal Guardian Name: _______________________________

Witness: ______________________________________

Legal Guardian Signature: ____________________________

Date: ________/__________ /__________________

Relationship to Patient: _______________________________