Women's Care Florida
OBSTETRICS & GYNECOLOGY ASSOCIATES
Since 1988

Exceptional Women's Care for Every Patient, Every Time

116 Parsons Park Drive · Brandon, Fl. 33511 · (813) 681-6625 · Fax (813) 699-1032
125A N Moon Avenue · Brandon, Fl. 33510 · (813) 643-6690 · Fax (813) 643-6930
13149 Elk Mountain Drive · Riverview, Fl. 33579 · (813) 675-8326 · Fax (813) 675-8336
1503 W. Reynolds Street · Plant City, Fl. 33563 · (813) 752-4103 · Fax (813) 759-6166

AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

_____ _____ _____
(Patient Name) (Date of Birth) (Social Security #)

_____ _____
(Complete Address) (Phone)

THE INFORMATION IS TO BE RELEASED BY:	**AND IS TO BE PROVIDED TO:**
Name of Facility	Name of Facility **OBSTETRICS & GYNECOLOGY ASSOCIATES**
Street Address	☐ 116 PARSONS PARK DR * BRANDON, FL 33511 ☐ 125A N MOON AVE * BRANDON, FL 33510 ☐ 13149 ELK MOUNTAIN DR * RIVERVIEW, FL 33579 ☐ 1503 W REYNOLDS ST * PLANT CITY, FL 33563
City, State and Zip Code	
Phone # and Fax, if possible	

THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD:

☐ All Medical Information and Reports

OR ONLY:

☐ Other (please specify):_____

_____

_____

All information I hereby authorize to be obtained from this facility will be held strictly confidential and can not be released by the recipient without written consent. I understand the authorization will remain in effect for ninety (90) days unless I specify and earlier date. I understand that after signing this release, there is a processing period of seven to ten business days.

_____
Signature of Patient or Person Legally Authorized to Consent for Patient *Date*

_____
Relationship to Patient (if applicable)

_____
Signature of Witness (must be an employee of OB/GYN Associates) *Date*