GENESIS OBGYN

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION CONSENT FORM

Date: _____

Patient's name _____

Patient's Date of Birth _____

Authorization for Use/Disclosure of Information

I voluntarily consent to authorize and direct Dr. Jennifer W. Seaton to disclose my health information to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Name _____

Address _____

Phone and fax numbers _____

Purpose

This authorization permits the above provider to disclose the following medical records: all of my health information that the provider has in his or her possession, including information related to any medical history, mental condition, physical condition and any treatment received by me. This includes all medical transcripts, radiology reports, and lab results including HIV/AIDS related information.

Term

I understand that this Authorization will remain in effect until the Provider fulfills this request.

Warning

This message is intended for the sole use of the person or entity to which it is addressed and contains privileged and confidential information, the disclosure of which is governed by applicable law. If you are not the intended recipient or the employee or the agent responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. The recipient of this information is obligated to maintain it in a safe, secure and confidential manner. If you have received this document in error, please notify the sender immediately by telephone or FAX so that we can arrange for the retrieval of these documents.

_____ _____

Patient signature Date

If the patient is unable to sign this authorization, please complete the information below:

_____ _____

Signature of guardian/representative Date

Genesis OBGYN
P.O. Box 728
Mary Esther, FL 32569
(850) 253-7400 Phone
(850) 200-4324 Fax