Women's and Children's Physicians of Naples/Drs. Jennifer & Louis Foley
2338 Immokalee Road, Box 152
Naples, FL 34110
Telephone (239) 566-7272
Fax (239) 319-2001

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION FOR:

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

PLEASE RELEASE RECORDS TO:

_____ (_____)_____
Name of Individual/Healthcare Provider/Facility — Fax number with Area Code

_____ (_____)_____
Street Address — Phone number with Area Code

_____ _____
City, State and Zip Code — **email address**

The information requested below will be used/disclosed for the following purposes: Ongoing medical care

I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

☐ **ALL MEDICAL RECORDS**

☐ **LAST VISIT ONLY (for pediatrics this will include growth chart and immunization records)**

☐ **OTHER (please specify) _____-**

I hereby authorize release of the above information, including psychiatric, alcohol, or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Women's and Children's Physicians of Naples, and hereby release the above from all legal liability that may arise from the release of the information requested. If, in the judgment of the medical staff, disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation, or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of information to the program's insurance carrier when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above stated purpose, this consent will automatically expire one year from the date signed. I further understand that Women's and Children's Physicians of Naples reserves the right to notify the above named person, corporation, or agency of my revocation in the event that I revoke this consent to release information.

_____ _____
SIGNATURE OF PATIENT OR IF MINOR PARENT/GUARDIAN — **DATE**

_____ (____)_____
PLEASE PRINT NAME — **PHONE NUMBER**