FLORIDA BLADDER INSTITUTE

Specialized Diagnostic, Treatment and Rehabilitative Care for Women with Incontinence, Pelvic & Bladder Disorder

1890 SW HEALTH PARKWAY, SUITE 205, NAPLES, FL 34109 OFFICE: 239-449-7979 FAX: 239-593-3356

www.floridabladderinstitute.com

AUTHORIZE:

_____

Name of Provider/Healthcare Facility

_____

Street Address

_____

City, State, Zip

Phone: _____ Fax: _____

RELEASE RECORDS TO:

Florida Bladder Institute

Name of Provider/Healthcare Facility

1890 SW Health Parkway Suite 205

Street Address

Naples, FL 34109

City, State, Zip

Phone: 239-449-7979 Fax: 239-593-3356

Email Address: XXXXXXXXXXXXXXXX

If copy of records are released to patient, do we (circle one) Mail a copy / email to patient / fax to patient

Patient Name _____ Birth Date _____SS # XXXXXXXX

I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

Please check appropriate areas.

- ❑ Complete Medical Chart
- ❑ History and Physical
- ❑ Discharge Summary (Date: _____)
- ❑ Psychiatric/Psychological
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Reports to Referral Source
- ❑ Operative Reports (Date: _____)
- ❑ Other (specify) _____

I hereby authorize the 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 Especially For Women. I 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 the 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 on year from the date signed. I further understand the Especially For Women 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.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____