Visionary Woman Care, LLC
at Visionary Centre for Women

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Authorization for Release of Medical Records

Medical Records # _____

Name of Patient (Please Print): _____ Date of Request _____

Patient may also be know as: _____

Date of Birth: _____ Social Security # _____

I hereby authorize: _____
(D.O., M.D. or Hospital) to furnish information from the medical record(s) of the patient named above, or to reproduce the record(s) in whole or in part.

If over 20 pages, PLEASE MAIL to:
Visionary Woman Care
Jennifer S. Hayes, DO, FACOOG
2695 Ulmerton Rd.
Clearwater, FL 33762

Information Requested: _____

This will Release: _____ (D.O., M.D. or Hospital) from all legal liability that may arise as a result of the release of the above information.

_____ _____
Signature of Patient or Parent, if Minor Date

_____ _____
Signature of Witness Date

I UNDERSTAND AND AGREE THAT A COPY OF ☐ **HIV Testing** ☐ **Drug Alcohol Screening Result** and/or ☐ **Psychiatric Records** will be released if requested

_____ _____
Signature of Patient or Parent (if Minor) Date

_____ _____
Signature of Witness Date

"This information has been disclosed to you from records whose confidentiality is protected by state law. Florida Statute 361.609 prohibits you from mailing any further discloser of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law."