SOUTHWEST FLORIDA
WOMEN'S GROUP

Betsy L. Brothers, M.D. *Board Certified*
Jennifer Bevins, M.D. *Board Certified*
Rose Nguyen, D.O. *Board Certified*
Maria Gabriela Pachori, M.D. *Board Certified*
Alfonsina Garcia, M.D. *Board Certified*

# AUTHORIZATION AND CONSENT TO RELEASE MEDICAL RECORDS

Patient Name:_____ Birthdate:_____

I hereby authorize release of the following information:_____

_____

For the purpose of:_____

Send records from: To:

SW Florida Women's Group _____

1890 SW Health Pkwy. #303 _____

Naples, FL 34109 _____

I hereby authorize release of the above information, including psychiatric, alcohol or drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Southwest Florida Women's Group 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, corporations or agency which is or may be liable for all or part of the physician charges or to 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 Southwest Florida Women's Group 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:_____ Date:_____

Parent/Guardian:_____ Date:_____

Witness:_____ Date:_____

**PLEASE MAIL OR FAX TO SW FLORIDA WOMEN'S GROUP**
FAX# 239-593-0812

REV: 8/25/2020