AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

To: Southwest Florida Fertility Center, P.A.
Jacob L. Glock, M.D.
15730 New Hampshire Court unit 101
Ft. Myers, Fl. 33908
239.561.3430 Fax 239.561.6980

You are hereby authorized to release and disclose the information from my medical record. I agree to the release and / or faxing of all of my medical records pertaining to HIV, sexually transmitted diseases, drug / alcohol abuse and psychiatric records.

FORWARD MEDICAL RECORDS TO:

Physician: _____

Address: _____

_____

City/State/Zip: _____

Phone: (_____) _____

Fax: (_____) _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Medical Record #: _____

PLEASE INCLUDE: (PATIENT MUST INITIAL EACH REQUEST)

_____ Physician / Nurse / Staff Notes and / or dictation

_____ Pertinent X-Ray copies and / or narratives

_____ Lab values, including HIV and Hepatitis

_____ Pathology reports

_____ Operative roports

_____ Psychiatric records

_____ Medical records from other physicians contained within my chart

_____ Other: _____

**Note: The statute regarding the release of medical records states that the office may charge $1.00 per page for the first 25 pages and $.25 per page thereafter. I understand that I have _____ pages as part of my medical record and that the charge for copying the record will be $_____. I understand that the copying fee must be paid in full prior to my medical record being copied.

_____ _____
Signature of consenting party Date

_____ _____
Relationship if other than patient Date

_____ _____
Witness (Required) Date