Tubal Reversal Experts
Authorization for Release of Medical Information

Edward Zbella, MD   *Mark Sanchez, MD*

Patient Name: ______________________________________ Social Security #: _________________________

Date of Birth: ____________________________ Home/Cell Phone #: ____________________________

I hereby authorize the release of my medical information

To: **Tubal Reversal Experts - Fax (727) 796-8764**

From: Hospital Name ____

Street Address ____

City ___________________________________ State __________ Zip Code ________________

Medical Record: Phone ___________________________ Fax ________________________________

You may disclose the following Medical Information: □ Operative Report from Tubal Ligation □ Pathology Report from Tubal Ligation □ Other ____

Time Period of Records: ____

The following items **will not** be released **without** my authorization. I authorize the disclosure of:

- □ HIV/AIDS information as protected by Florida Statute 381.004(3)(f). Patient Initials: ________
- □ Psychiatric/Psychological information as protected by Florida Statute 456.057. Patient Initials: ________
- □ Drug/Alcohol abuse information as protected by Florida Statute 397.501. Patient Initials: ________
- □ Sexually transmitted disease information as protected by Florida Statute 381.29 Patient Initials: ________

This authorization will be valid for 180 days after the date of the patient's signature as it appears below.

PATIENT RIGHTS: I understand that I do not have to sign this authorization in order to receive health care services. However, I do have to sign an authorization form when the purpose is to provide my medical information to a third party.

I understand that I have the right to revoke this authorization at any time, provided that I do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

I understand that once my medical information has been disclosed to the named person/organization listed in this authorization, Privacy laws may no longer protect it, and the named person/organization may re-disclose it.

____ Date: __________________________

Signature of Patient

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TUBAL REVERSAL EXPERTS
www.TubalReversalExperts.com