

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TUBAL REVERSAL EXPERTS

Edward Zbella, MD

Mark Sanchez, MD

To: _____

Address: _____

City, State, Zip _____

RE: _____

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Phone Number: _____

I hereby request you to release to: **Tubal Reversal Experts**
2454 N. McMullen Booth Rd
Suite 601
Clearwater, FL 33579
Phone: 727-796-7705
Fax: 727-796-8764

all medical information from my health record, **pathology and operative reports** pertaining to my tubal ligation and all records for the purpose of continuity of care.

I understand that all medical information is my confidential property, that the patient records are the property of Tubal Reversal Experts, and that I will not hold Tubal Reversal Experts, or its representatives responsible for any mental or physical damage which may be caused by the receipt of these records by myself or others.

Patient Signature

Date

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SPECIAL AUTHORIZATION FOR RELEASE OF HIV TEST RESULTS AND/OR AIDS DIAGNOSIS TREATMENT. (IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN) CHECK BOX IF THIS INFORMATION IS TO BE RELEASED.

HIV antibody test and/or AIDS diagnosis treatment, as per Florida Statute 381.004

Patient Signature

Date