Authorization to Release Medical Information to
Dr. Catherine L. Cowart, M.D.
Reproductive Health Associates
2695 Ulmerton Rd.
Clearwater, FL 33762

Name _________________

Date of treatment (if applicable) ____________________

This is a request that authorizes all physicians, hospitals and medical attendants to furnish to the address above my complete and entire medical record of my treatment, diagnosis and tests including but not limited to: all medical reports and records, nurse's notes, x-rays, laboratory data, and all other information.

This request and authority includes examination of originals of hospital records, admission and discharge records, X-rays, slides, and all other data, information and materials related to my treatment, including medical reports and opinions, and all lab data, with no exceptions.

Please include a copy of each and every page of the medical record including but not limited to all notes written and dictated by physicians, consultants, nurses, and other health care providers.

All previous authorizations are cancelled, except those which permit release of information to facilitate payment of outstanding bills by any health insurance carrier.

Please do not permit anyone else to inspect my records.

Date_______________

Name________________

Signature______________

Address________________

City, State_________________