



LOUIS M. COLIAZO, M.D., F.A.C.O.G.
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EMILIO A. BLANCO, M.D., F.A.C.O.G.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date: _____

I HEREBY REQUEST AND GIVE AUTHORITY TO PREMIERE OB/GYN TO RELEASE A COPY OF MY MEDICAL RECORD TO:

Physician/Hospital/Other: _____

Address: _____

Fax: _____ Phone: _____

PATIENT TO DESIGNATE RECORD(S) TO BE RELEASED:

Patient Signature

I agree that any and all medical information may be released, including but not limited to mental health, drug or alcohol use, HIV/AIDS test results and other records protected by state and federal laws.

Patient Signature

I request that the release of medical information be restricted to the following portions of my medical record:

I understand that this authorization is valid for 60 days from the date of my signature.

Patient or Parent/Legal Guardian Signature Date: _____

Dvaile@premiereobgyn.com

Memorial Regional
1150 N. 35th Ave., Ste. 405
Hollywood, FL 33021
(954) 961-9993 • Fax (954) 961-0163

Memorial West
601 N. Flamingo Rd., Ste. 401
Pembroke Pines, FL 33028
(954) 961-9993



Premiere Obstetrics & Gynecology

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AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date: _____

I HEREBY REQUEST AND GIVE AUTHORITY TO PREMIERE OB/GYN TO OBTAIN A COPY OF MY MEDICAL RECORD FROM:

Physician/Hospital/Other: _____

Address: _____

Fax: _____ Phone: _____

I HEREBY REQUEST A COPY OF MY MEDICAL RECORD BE RELEASED TO:

Premiere Ob/Gyn
1150 N. 35th Avenue, Suite 405
Hollywood, Florida 33021
Phone: (954) 961-9993 / Fax: (954) 961-0163

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