NANCY A CARLSON, MD
Individualized Women's Healthcare
10201 ARCOS AVE
SUITE 103
ESTERO FL 33928

LUMINA

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Phone_____

This release will authorize Nancy A. Carlson, MD, PC

To obtain records from _____
_____
_____

To send records to _____
_____
_____

A complete copy of my medical records related to my medical diagnosis, treatment and condition.

I understand that I have the right to inspect a copy of the information to be disclosed and that I may withdraw this authorization at any time, except to the extent that actions have been taken based on this authorization.

I hereby authorize Nancy A. Carlson, MD to release/obtain records of my treatment, including drug, alcohol, depression, HIV/AIDS, hepatitis or other sexually transmitted disease unless specified below.

I want the following information released/obtained from:

_____
_____
_____

I understand that this authorization will expire, without my express revocation, one year from the date signed.

Please mail or fax the records t0 :

Nancy A. Carlson, MD
10201 Arcos Ave, Suite 103
Estero, Florida, 33928
Phone: 239-399-8019
Fax: 239-984-8965

_____ _____
Signature of Patient Date