Tami Horner, MD

NAME: ________________________________ DATE OF BIRTH: ________________________

ADDRESS: ______________________________ SOCIAL SECURITY: ______________________

____

AUTHORIZED RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI)

FROM:

Physician's Name:

____

Address:____________________________

____

Phone: ____________________________

Fax: ____________________________

TO:

SUCCESS BY DESIGN

9095 BELCHER RD

PINELLAS PARK, FL 33782

PH: 888-530-0599 / FAX: 727-258-4865

This authorization expires __________________ (unless otherwise stated, authorization expires six (6) months from date of authorized signature)

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

I want the following information to be disclosed:

- ☐ Most Recent Pap Smear
- ☐ Most Recent Pelvic Exam
- ☐ Most Recent Mammograms
- ☐ Most Recent EKG
- ☐ Most Recent Stress Test/Echo/EKG
- ☐ All labs within last _________ months
- ☐ Other: ____

The purpose of this disclosure is:

______________________ Physician's Request ______________________

Please be aware that information disclosed pursuant to this authorization is subject to Re-disclosure by the recipient and is no longer protected by this organization.

____ Date:____________________

Signature of Patient or Representative (Required)

____

If Representative, authority on which acting for the Patient

9095 Belcher Road

Pinellas Park, FL 33782

Tax ID# 80-0562636

Ph: 888.530.0599 Fax: 727-258-4865