Elizabethtown Physicians for Women, PSC

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ Other Last Names Used_____
Date of Birth: _____ Social Security#_____

I hereby authorize records **FROM** _____
Address:_____
Phone#_____Fax#_____
and its physicians, employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I hereby authorize the release of these medical records **TO**: _____
Address:_____
Phone#_____Fax#_____
MAIL RECORDS_____CALL ME TO PICK UP_____WILL BE PICKED UP BY_____
Purpose of disclosure (check one): _____ Future Evaluation and Treatment
_____ At the Request of the Patient
_____ Transfer Care to another Physician
The authorization will expire on: _____
(Date or Event may not exceed one year)

This request and authorization applies to:

_____ All office records including records from services not billed to my insurance company

_____ Health care information relating to the following treatment, condition or dates of treatment
_____
_____

_____ Specific records to be released (eg. Labs, imaging reports, other)
_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.
_____Substance abuse _____ Psychological or psychiatric treatment _____ HIV/AIDS/STD
I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative Date Signed

Relationship to Patient