



THE WOMEN'S HEALTHCARE GROUP
1693 South Queen Street York, Pennsylvania 17403
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www.womenshealthcaregroup.com

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*This Authorization will not be accepted unless it is completed in its entirety.
 A copy of this form will be accepted in lieu of an original.*

I hereby authorize **The Women's Healthcare Group** to receive from: _____
1693 South Queen Street disclose to: _____
York, PA 17403 _____

 Street Address

 City State ZIP Fax # if necessary

the following information regarding my care on _____
 Specify Date or Range of Dates

Please Check below:

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Imaging or Lab Reports |
| <input type="checkbox"/> Other (please specify) | | |

Please indicate the purpose for disclosing the above information by checking an option below:

- Attorney Request Insurance Request Moving Out of Area Disability Application
- WHCG does not participate with your insurance (please indicate name of your insurance company) _____
- Changing Providers (in an effort to continuously improve our customer service, please briefly indicate the events leading up to your decision to leave our Practice) _____

Please note that a charge will be assessed for any records disclosed directly to the patient.

This information is being disclosed to the above person, organization, or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P. L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law, 93-282) and/or Confidentiality of HIV Related Information Act (Pennsylvania Law, Act 148). My signature below authorizes release of all such information by routine/express mail service or facsimile transaction.

I understand that I have no obligation whatsoever to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I also understand that this authorization includes the release of knowledge if I maintained my financial responsibility in a satisfactory manner. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated.

This authorization shall expire 30 days from the date executed under Pennsylvania State Law Act 63. All other authorizations expire 6 months from the date executed unless otherwise specified by the patient.

Print Patient's Full Name	Responsible Party if not Patient	Patient's Date of Birth
Signature of Patient/Responsible Party	If Responsible Party/Relationship	Date
Witness Signature	Date	