THE WOMEN'S HEALTHCARE GROUP
1693 South Queen Street, York, Pennsylvania 17403
717-845-1621 Fax 717-854-6939
www.thewhcg.com

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.
You will be required to show photo identification before release will be accepted by this Practice.

I hereby authorize **The Women's Healthcare Group** to:

❑ receive from: _____ ❑ disclose to: _____

_____ _____

_____ _____

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

Dates of Service: ☐All ☐Date Range: _____
Description of information: ☐Entire Record ☐Other (specific type) _____
Special Records: The following information will be release. Please write your initials next to any items you **do not** want to be released:
____ AIDS/HIV related information (protected by Confidentiality of HIV-related Information Act, 35 P.S. 7607)
____ Mental health information (protected by the Mental Health Procedures Act, 50 P.S. 7111)
____ Drug & Alcohol abuse or dependency information (protected by the PA Drug & Alcohol Abuse Control Act, 71 P.S. 1690.108)

Please indicate the purpose for disclosing the above information by checking an option below:
❑ Attorney Request ❑ Insurance Request ❑ Moving Out of Area ❑ Disability Application
❑ Second Opinion/Consultation ❑ 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) _____

I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation and will not apply to information that has already been released in response to this authorization.
This authorization is voluntary. I can refuse to sign this authorization.
I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.
I understand that this information may be re-released by the recipient and no longer protected.
By signing below, I certify that I understand the nature of this Release.
I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
If mental health records are being released as permitted by the Mental Health Procedures Act, I understand that I have a right, subject to 55 Pa. Code 5100.33, to inspect the material to be released.
If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by PA law. PA law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.
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 **Signature of Patient** **Patient's Date of Birth**

_____ _____ _____
Today's Date **Witness Signature** **Today's Date**

_____ _____
Responsible Party if not patient/relationship **Signature of Responsible Party**