Authorization for Release of
Protected Health Information

Gynecology Care Specialists
136 Jaycee Drive, Suite 10
Johnstown, Pa. 15904
814-961-6180 Fax: 814-254-4008

____ ____________________ ____________________
Patient Name Date of Birth Patient Phone Number

____
Patient Address

Reason for release: ( ) Continuity of Care ( ) Insurance ( ) Legal ( ) Self ( ) Other (specify) ______________________________

I hereby authorize Gynecology Care Specialists to: ( ) Obtain information from OR ( ) release information to:

____ ______________________________
Name / Facility Telephone Number

____ ______________________________
Address Fax Number

Treatment Dates: Outpatient _______/_______ Emergency _______/_______ Inpatient _______/__________

PLEASE SELECT WHAT DOCUMENTS YOU WANT TO BE INCLUDED IN THIS RELEASE REQUEST:

____ History & Physical
____ Provider Notes
____ Laboratory Reports
____ Radiology Reports
____ Pathology Reports
____ Emergency Room Report
____ Operative Reports
____ EKG/Cardiology Report
____ Medication Record
____ Nursing Notes
____ Discharge Summary
____ ASU Treatment Record
____ Clinic Notes
____ Consultations

Other, specify ____

There are no limitations placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment, except as identified and specified immediately below:
ITEMS OR DATES TO EXCLUDE: ____ Initial here ____________

Revocation Process: I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to the authorization. I understand that the revocation of this authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. <u>This authorization will expire six months from the date of my signature.</u>

Right to Copy/Voluntary Disclosure: I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary. I acknowledge that my records may be redisclosed in accordance with federal or state law.

Health Plan/Insurance Issuers-Conditions: I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and consequence to me should I refuse to sign this Authorization.

Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization may deny the release of protected health information if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested or (4) if this authorization has expired.

Fees: It is understood and agreed that the individual presenting this authorization for release of medical records will pay Pennsylvania regulated fees charged for this service as required by law, as posted by the Department of Health at www.health.pa.gov/topics/administrative/pages/ medical-record-fees.aspx
By signing below I represent that I authorize release of otherwise protected health care information to the person or entity identified above.

______________________________________ ______________________________________
Patient's Signature (Photo ID required) Date/Time Signature of staff who obtained the consent Date/Time

______________________________ ______________________________
Signature Authorized Individual Date/Time Relationship to Patient

____
Print Name of Authorized Individual

NOTICE TO PARTY RECEIVING INFO: This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by prior written consent of the person to whom it pertains.