WHITE ROSE OB/GYN ASSOCIATES
1225 East Market St
York PA 17403
PHONE # 717-845-9639, FAX # 717-699-1300

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize (Office name and address) _____

_____

to OBTAIN FROM or DISCLOSE TO (circle one):

Office Name and Address: _____

_____

the following information from my medical record: (please specify dates)

( )Office notes
( )Hospital Discharge Summary
( )Consultations
( )Other specify_____
( )History and physical exams
( )Records from other doctors
specify:_____
( )Xrays, Imaging reports
( )Lab reports
( )Cardiac/EKG reports

The purpose for disclosing the above information is indicated by a check mark below:

( )Continuing care ( )Relocation ( )Insurance ( )Legal ( )Other specify:_____

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the Practice Manager of this office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

The signing of this authorization is not a condition for providing treatment.

I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed pre Pennsylvania state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists.

Records NOT to disclose: ( )HIV information; ( )Mental health services; ( )Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of the document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE EXECUTED UNLESS OTHERWISE SPECIFIED BY THE PATIENT.

_____

Print Patients full name

Signature of Patient/responsible party

Date

Patients Date of Birth

Relationship to Patient

Patients Social Security Number

Witness Signature

Date

NOTE: 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.
A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PATIENT OR THE PATIENT REPRESENTATIVE.