Susquehanna Obstetrics, Gynecology, & Nurse Midwifery

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SPECIFIC AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Facility Name: _____

Facility Phone Number: _____

Facility Fax Number: _____

Are we requesting the records from your previous practice or are we releasing the records to your new/current practice? (Circle one): Requesting Releasing

Medical Records Concerning: _____

I understand that the medical records to be released may contain information related to HIV status, AIDS, venereal diseases, alcohol and drug use, cancer diagnosis, or mental health services, and hereby authorize the release of this information. This authorization for disclosure is valid for a period of (1) year and may be withdrawn by me and any time except during an action taken in response thereon.

_____ _____

Signature of Patient (or personal representative/guardian/guarantor) Date

Advantia