

Women's Health Care Group of PA
Great Valley OB/GYN

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ DOB: _____

I, _____, hereby authorize **Great Valley OB/GYN**
To obtain () release () the following specific information regarding treatment
Dates: _____

INFORMATION TO BE RELEASED TO:

Individual or organization: _____

Address: _____

I understand that this information is being requested for the specific purpose of:

I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) by written or oral communication to the medical record custodian of this physician(s)' medical practice, under Pennsylvania Law (Act 148). If psychological reports are to be sent, I have been informed of my rights, subject to Section 5100-34 of the Mental Health Procedures Act 1984, to inspect the information to be released.

THIS CONSENT SHALL BE IN EFFECT FOR 180 DAYS FROM THE DATE
SIGNED UNLESS SPECIFIED OTHER WISE BY THE PATIENT TO EXPIRE ON
_____ (CANNOT EXCEED 180 DAYS).

MO/DAY/YR

_____ Date _____

Signature of patient/ Legal Guardian

Witness Relationship/Title Date

INSTRUCTIONS:

1. Complete all blanks
2. Return form with original signature(s)
3. Return for "Attention Medical Records"
4. Fee of \$20.00 payable by Check, Cash or Credit