# Susquehanna Obstetrics, Gynecology and Nurse Midwifery

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## SPECIFIC AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION - MEDICAL RECORDS

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**Medical Records of Patient:** _____

**Date of Birth:** _____ **Social Security #** _____

**To be Released To/Obtained From: (circle one)** _____

**Address:** _____

**Phone Number:** _____ **Fax Number:** _____

**Reason for Release: (please check one)** _____ **2nd Opinion:** _____ **Transferring**

_____ **Other, Explain:** _____

**The undersigned hereby authorizes and requests Susquehanna Obstetrics, Gynecology and Nurse Midwifery to provide or obtain copies of the medical record of the above named patient. This authorization is valid for:**

____ Any and all information related to past & present medical history, diagnoses, & treatments.
____ The medical records concerning the period _____.
____ The medical records regarding a specific diagnosis or treatment of _____.

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 This authorization for disclosure is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon.

_____ _____
Signature of Patient Date
(or patient's personal representative/guardian/guarantor)

_____ _____
Relationship to patient or other authority Witness