Mid Atlantic Gynecologic Oncology and Pelvic Surgery Associates

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Authorization for Release of Information

Patient : _____ DOB: _____ File Number: _____

I hereby authorize _____
(Name of physician, hospital, or health care provider)

to release my personal health and medical information as described below to the following person(s)
_____
_____
[*Name and address(es) of person(s) to receive information*]
for the following purpose(s):_____

This information includes (check all that apply):

- ☐ Medical Records
- ☐ Behavioral Reports
- ☐ Psychological Evaluation
- ☐ Court Report
- ☐ Other (describe below)
- ☐ Neurological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment/Discharge Summary
- ☐ Substance Abuse Information
- ☐ Urine Screen/Breathalyzer Results

_____

The information to be shared covers the following period(s) of treatment or care:
From (date) _____ to (date) _____

This authorization will expire on _____ (date or event), unless revoked by the undersigned.

This release, made freely and voluntarily, shall remain for the period noted above and may be revoked at any time with written notification executed by the responsible party noted below, except to the extent that action based on this consent has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for treatment or benefits.

I understand that I may inspect or receive a copy of the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.

I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy, fax, or electronically transmitted version of this document has the same force and effect as the original.

_____ _____
Signature of patient /guardian/patient's representative Date

If signed by other than patient, indicate relationship: _____

Printed name of patient's representative: _____

If prepared and/or witnessed by a Mid-Atlantic Employee: _____ (Employee name)