Dedicated to Women

Release of Health Information Authorization

NAME: (Last, First, MI): ______________________________ D.O.B: ______________

PHONE #: ____________________ ADDRESS: ______________________________

I, the above name patient, hereby authorize the release of my protected health information.

This form must be completed in it's entirety by the patient or patient representative in order to be processed.

I authorize the release of my records FROM:	I authorize the release of my records TO:
PHYSICIANS/ PRACTICE/ FACILITY NAME	PHYSICIAN/ PRACTICE/ FACILITY NAME
ADDRESS OF FACILITY	ADDRESS OF FACILITY
PHYSICIAN PHONE/ FAX/ EMAIL	PHYSICIAN PHONE/ FAX/ EMAIL

The information I wish to have released is:

☐ All ☐ Ultrasound Results ☐ Mammogram ☐ Labs ☐ Pap Results ☐ Prenatal Records ☐ Substance Abuse ☐ HIV/AIDS

☐ Genetic Testing ☐ Mental Health Care ☐ STD Results ☐ Specific Dates of Service: ______________ ☐ Other ______________

The purpose for the release of the health information: ☐ Transfer of Care ☐ Legal ☐ Other ______________________

Duration of Authorization: Unless otherwise specified, this authorization will expire one (1) year after the date of this request.

This Authorization will expire: ☐ Date: ______________________

Fees for copying medical records and processing time frame:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- $2.00 per page for pages 1-10, $1.00 per page for pages 11-20, $0.90 per pages 21-60, $0.50 for pages 61 and greater.
- There is an additional charge for postage.
- Please allow 2-3 weeks for processing.

Certification and Acknowledgment: I certify that I am the patient or the patient's legal representative. I understand that I may revoke this authorization at any time by notifying Dedicated to Women in writing. Revocation will not apply to information that has already been disclosed in response to this authorization, and that the revocation will be effective except to the extent that Dedicated to Women has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules.

Signature: ______________________________________ ***Date:*** ______________

If signing as the personal representative of the person, print your name and describe your authority to sign for the person and attach any legal documentation which authorizes signature on the member's behalf (Power of Attorney, Guardianship, etc.)

Name: ______________________________ *Authority:* ______________________

FOR OFFICE USE: ☐ Records sent on ______________ ☐ Transfer Group notified: ______________

118 Sandhill Drive, Ste 203
Middletown, DE 19709

200 Banning Street, Ste. 320
Dover, DE 19904

806 Seabury Avenue
Milford, DE 19963

18947 John J Williams Highway
Beebe Health Campus, MAC
Rehoboth Beach, DE 19971

Phone: (302) 674-0223 Fax: (302) 674-0109ÁÁÁÁÁÁÁÁ¸ ¸ ¸ Èå^åã&æ^åq ¸ [{ ^}[à*^}È&[{ ÁÁ