Womens Gynecologic Associates
Karen E. Rehder, M.D.
Practice Limited to Gynecology
Sandra J. Hazel, Office Manager
580 S. Aiken Avenue, Suite 500
Pittsburgh, PA 15232
Tel: 412-688-3653 Fax: 412:687-4054
Appointments Scheduled Monday - Friday 8:00 a.m. - 3:00 p.m.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION to WOMENS GYNECOLOGIC ASSOCIATES

I hereby authorize ______________________________ to release information from the record of:
Name of Facility/Person

______________________ ______________ ______________ as described below to
Patient Name | Birth Date | SSN

WOMENS GYNECOLOGIC ASSOCIATES | 412-688-3653 | 412-687-4054
Name of Facility/Person | Phone | Fax

580 S. AIKEN AVENUE, SUITE 500 | PITTSBURGH | PA | 15232
Address | City | State | Zipcode

Records are requested for the purpose of (**PROVIDE A DETAILED DESCRIPTION**):______________________________

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE ADMINISTRATIVE FEE CHARGED FOR THE COPYING OF MY MEDICAL RECORDS.

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Tvpe of records to be released **and** approximate date(s) of service (check all that apply):

- ❑ Inpatient; Dates:
- ❑ Emergency Dept; Dates:
- ❑ Outpatient; Dates:
- ❑ Physician Office/Clinic; Dates:

2. Specific information to be released (check all that apply):

- ❑ Consultation Reports
- ❑ Discharge Summary
- ❑ Laboratory Reports/Tests
- ❑ Mammography Report
- ❑ Emergency Dept. Report
- ❑ Other, specify:
- ❑ Medical History & Physical Exam
- ❑ Medication Administration Records
- ❑ Operative Report
- ❑ Pathology Report
- ❑ EKG Report(s)
- ❑ Physician Orders
- ❑ Progress Notes
- ❑ Psychiatric/Psychological Eval
- ❑ Radiology Report
- ❑ Discharge Instructions

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ❑ HIV ❑ Mental Health (Psychiatric) ❑ Drug & Alcohol

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here:

Date of Signature | Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) | Date of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

Date of Signature | Witness/Staff Member Signature

Authorized Representative's relationship and authority to act on behalf of patient:______________________

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date | Witness #1 | Date | Witness #2

Revised 10/22/2013

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION from WOMENS GYNECOLOGIC ASSOCIATES TO ANOTHER PROVIDER

I hereby authorize ______WOMENS GYNECOLOGIC ASSOCIATES______ to release information from the record of:
Name of Facility/Person

______________________ Patient Name ______________ Birth Date ______________ SSN as described below to

______________________ Name of Facility/Person ______________ Phone ______________ Fax

______________________ Address ______________ City ______ State ______ Zipcode

Records are requested for the purpose of (**PROVIDE A DETAILED DESCRIPTION**):______________________

____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Tvpe of records to be released **and** approximate date(s) of service (check all that apply):
   - ❑ Inpatient; Dates:
   - ❑ Emergency Dept; Dates:
   - ❑ Outpatient; Dates:
   - ❑ Physician Office/Clinic; Dates:

2. Specific information to be released (check all that apply):
   - ❑ Consultation Reports
   - ❑ Discharge Summary
   - ❑ Laboratory Reports/Tests
   - ❑ Mammography Report
   - ❑ Emergency Dept. Report
   - ❑ Medical History & Physical Exam
   - ❑ Medication Administration Records
   - ❑ Operative Report
   - ❑ Pathology Report
   - ❑ EKG Report(s)
   - ❑ Physician Orders
   - ❑ Progress Notes
   - ❑ Psychiatric/Psychological Eval
   - ❑ Radiology Report
   - ❑ Discharge Instructions
   - ❑ Other, specify:

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ❑ HIV ❑ Mental Health (Psychiatric) ❑ Drug & Alcohol

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here:

______________ Date of Signature

______________ Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

______________ Date of Signature

______________ Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

______________ Date of Signature

______________ Witness/Staff Member Signature

Authorized Representative's relationship and authority to act on behalf of patient:______________________

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

______ Date ______________ Witness #1

______ Date ______________ Witness #2

Revised 10/22/2013

Summary Page

Patient: ______________________________ Date ______________________Age: _______

Allergies: Do you have a living will? Yes_____ No_______

1	4
2	5
3	6

Medications:

1	5	9
2	6	10
3	7	11
4	8	12

Medical Problems:

1	4	7
2	5	8
3	6	9

Past Medical Hx:

Operations	Hospitalizations
1	1
2	2
3	3
4	4
5	5

Soc Hx: [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Other Religion______________________

Occupation ______________________________ Spouse Occupation ________________________

Non-Smoker _____ yrs Smoker _____ ppd Alcohol ______ Drug use ___________

Fam Hx:

Cancer
Heart Disease
HTN
Diabetes
Other