DOCTORS · MIDWIVES · NURSES
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OBSTETRICS & GYNECOLOGY
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SUSQUEHANNA VALLEY
Women's Health Care

Medical Records Fax: 717-397-2234
Electronic Fax: 717-509-3115
Email: medical.records@maygrant.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize the release of my health information as listed below:

Patient Name:_____ **Date of Birth:**_____

Address:_____

_____ **Telephone:**_____

Provider or entity authorized to release information:_____

Person or entity authorized to receive information:_____

Address:_____

Description of information:_____

Date(s) of service:_____

Special Records: Medical Records to be released **will not include** records of drug and alcohol abuse program treatment, mental health treatment, confidential HIV and AIDs related information or sexual abuse/assault counseling records **unless the specific boxes below are checked**. Checking the boxes is not a representation that such information exists.

- ☐ Include drug and alcohol abuse treatment records
- ☐ Include mental health records
- ☐ Include Confidential HIV and AIDs related records
- ☐ Include sexual abuse/assault counseling records

Purpose of Release of Information:_____

_____

_____

1. This authorization will expire: ☐Date:_____ ☐Event:_____ ☐One year
   Unless otherwise specified, this authorization will expire 90 days after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer in writing at the above listed address. I understand that revocation will not have any effect on actions taken by Drs. May-Grant Associates before it received a revocation.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Printed Name of Patient's Representative **Relationship to Patient**

To Recipient: *Information regarding drug and/or alcohol use, abuse, treatment or referrals for treatment has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

Information regarding HIV information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.