WOMEN'S HEALTH CARE GROUP OF PA
Main Line OB/GYN Associates Division

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____DOB: _____
I, _____, hereby authorized _____
To obtain ( ) release ( ) the following specific information regarding treatment
Dates: _____

INFORMATION TO BE RELEASED TO:
Individual or organization: _____
Address:_____
_____
_____

I understand that this information is being requested for the specific purpose of:
_____

I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) by written or oral communication to the medical record custodian of this physician(s)' medical practice, under Pennsylvania Law (Act 148). If psychological reports are to be sent, I have been informed of my rights, subject to Section 5100-34 of the Mental Health Procedures Act 1984, to inspect the information to be released.

THIS CONSENT SHALL BE IN EFFECT FOR 180 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED OTHER WISE BY THE PATIENT TO EXPIRE ON :_____(CANNOT EXCEED 180 DAYS).
MO/DAY/YR

_____ Date _____
Signature of patient/ Legal Guardian

_____ _____ _____
Witness Relationship/Title Date

INSTRUCTIONS: 1. Complete all blanks
2. Return form with original signature(s)
3. Return for "Attention Medical Records"
4. Enclose a check for $20.00

85 Old Eagle School Road Strafford, PA 19087 P: (610) 688-3744 F: (610) 688-4490
4 Industrial Blvd., Suite 110 Paoli, PA 19301 P: (610) 688-3744 F: (610) 688-4490
599 Arcola Road Collegeville, PA 19426 P: (610) 454-7787 F: (610) 688-4490