



Medical Record Release Form

Please complete, sign and return this form to Delaware County Women's Center or submit via fax.

Patient Name: _____ DOB: _____

Phone number: _____

check here if we cannot identify ourselves as DCWC. ID as _____

I hereby authorize DCWC to release my protected health information to:

Myself Another facility/physician for treatment: _____
Facility/Physician Name

Fax/Email to: _____

Mail to: _____

Name	Address
City	State Zip Code

Hold for pick up by (valid identification will be required before records are released):

Name	Relationship
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Purpose of Disclosure:

Myself School/Work Appointment proof Legal Proof of Depo Administration

Treatment at another facility Other (specify): _____

Information to be released (check all that apply)

<input type="checkbox"/> Copy of ultrasound(s)	<input type="checkbox"/> Proof of Depo Shot	<input type="checkbox"/> Proof of PACA	<input type="checkbox"/> Billing info
<input type="checkbox"/> Full copy of chart (<i>may be subject to a charge</i>)	<input type="checkbox"/> For Completion of FMLA paperwork	<input type="checkbox"/> Appointment note with restrictions	

Other (*please describe and be as specific as possible*):

This authorization shall be in force and effect until: *(check one of the following)*

One Year from the date the Authorization is signed.

Date _____

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time, but that the revocation will apply only to uses and disclosures of my PHI after the revocation. I can request revocation by sending written notification to:

Delaware County Women's Center
Attn: Privacy Officer
CCMC Annex- Alexander Silberman Center
1 Medical Center Blvd., 4th Floor
Upland, Pa 19013

I understand that authorizing the disclosure of this health information is voluntary and that the facility will not condition my treatment on whether I provide authorization for the requested use of disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect or copy the information to be disclosed for a reasonable charge.

I have carefully read and understand the above, have had any questions explained to my satisfaction and to herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Patient Signature _____

Date _____

-For Staff Use Only-

Request completed in the presence of _____ or Request received via fax/email

Request fulfilled by _____ Date/Time _____

Entered in Centricity _____ Date/Time _____