The Reading Hospital Medical Group
www.thrmg.org

All About Women
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please fill out the following questionnaire and bring it with you to your appointment. This information is very important to your health. Please take time to fill out this information fully and completely.

Specific information to be released:

- ☐ Verbal/Telephone/e-mail contact
- ☐ Summary of Treatment
- ☐ Office Notes
- ☐ Reports from labs or other outside studies
- ☐ Other _____

☐ I hereby authorize the following person(s) and/or organization(s) to release the above information to:

_____

_____

And/Or

☐ I hereby authorize _____ to release the above information to the following person(s) and/or organization(s):

Person(s) and/or Organization(s)

_____ _____

_____ _____

_____ _____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified: _____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

Special Authorization: **My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the type of records indicated by my initials below:**

____ Behavioral/Mental Health ____ HIV/AIDS ____ Alcohol/drug abuse/dependence

X _____ _____

Signature of Patient (if 18 or older); Or Parent (if patient under 18); Or Legal Guardian; or Health Care Agent

Signature of Witness

X _____ **X** ____/____/____ _____ ____/____/____

Printed Name of Patient or Authorized Person

Date

Printed Name of Witness

Date

X ____/____/____ _____

Patient's Date of Birth

Title of Authorized Person (if applicable)