Girls to Women HEALTH AND WELLNESS

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Young Men's HEALTH AND WELLNESS

Patient Name: _____ Date of Birth: _____/_____/_____

Please provide me with a printed copy of the above patient's medical records.

Information to be disclosed. If all health information is to be released, then check only the first box.

- ☐ ALL Health Information: including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
- ☐ Immunization Records/Growth Charts
- ☐ Lab/Radiology/Testing Reports
- ☐ Mental Health Records (excluding psychotherapy notes)
- ☐ Other (please specify): _____

Patient's Initials are required to release the following information:

____ Mental Health Records (excluding psychotherapy notes)
____ Drug, Alcohol or Substance Abuse Records
____ Genetic Information (including Genetic Test Results)
____ HIV/AIDS Test Results/Treatment

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Girls to Women Health and Wellness, PA and Young Men's Health and Wellness. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize Girls to Women Health and Wellness, PA and Young Men's Health and Wellness to use or disclose my health information in the manner described above. This authorization expires upon my written request.

I understand that there will be a charge of $25 for the first 20 pages and 50¢ for each page thereafter for medical records provided in a paper format.

_____ I will pick up the medical records at the clinic.

_____ Please mail the records to: _____

I understand that I will need pay for the records and the mailing costs prior to receipt of the records.

Patient's Signature (18 years of age and older): X_____ _____/_____/_____
Patient Signature (adult patients only) Date

Minor's Signature

A minor individual's signature is required for the release of certain types of information , including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

X_____ _____/_____/_____
Patient Signature (minor patients only) Date

Parent/Guardian's Signature Specify relationship to patient ☐ Parent of Minor ☐ Guardian ☐ Other: _____

X _____ X_____ _____/_____/_____
Parent/Guardian (print) (if patient is a minor) Parent/Guardian Signature (if patient is a minor) Date