Girls to Women HEALTH AND WELLNESS

Young Men's HEALTH AND WELLNESS

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

☑ **ALLOW COMMUNICATION** to and from the below PROVIDER and Girls to Women Health & Wellness, Young Men's Health and Wellness, our in-house licensed therapists/dietitians as needed including all medical and mental health protected health information (excluding psychotherapy notes). I authorize the following providers to disclose the patient's protected health information for treatment/continuing medical care.

☐ In addition, **REQUEST** protected health information **FROM** the below **PROVIDER:**

- ☐ Complete Records
- ☐ Immunization Records ☐ Growth Charts ☐ Lab/Radiology/Testing Reports
- ☐ Mental Health Records (excluding psychotherapy notes)
- ☐ Other (please specify): _____

☐ In addition, **SEND** protected health information **TO** the below **PROVIDER:**

- ☐ Complete Records
- ☐ Immunization Records ☐ Growth Charts ☐ Lab/Radiology/Testing Reports
- ☐ Mental Health Records (excluding psychotherapy notes)
- ☐ Other (please specify): _____

PROVIDER

Name: _____ **Phone:** _____

Practice/Group Name: _____

Address: _____ **Fax:** _____

REQUIRED PATIENT INTIALS for Release of ANY GTW/YM Records

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

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.

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.

REQUIRED PATIENT SIGNATURE X_____ _____/_____/_____

Patient Signature Date

Parent/Guardian's Signature (Only required for patients less than 18 years of age):

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