

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)
- \_\_\_\_ Genetic Information (including Genetic Test Results)
- \_\_\_\_ HIV/AIDS Test Results/Treatment
- \_\_\_\_ Drug, Alcohol or Substance Abuse Records Substance Use Disorder (SUD) Treatment Records, including drug and alcohol treatment records protected under 42 CFR Part 2. I understand these records carry heightened federal confidentiality protections and that re-disclosure by the receiving party may not be restricted by those protections.

**IMPORTANT NOTICE REGARDING RE-DISCLOSURE:** Please be aware that once your protected health information is disclosed to the receiving provider pursuant to this authorization, that information may be subject to re-disclosure by the recipient and may no longer be protected under federal confidentiality laws, including 42 CFR Part 2 (which governs substance use disorder treatment records). Girls to Women Health & Wellness and Young Men's Health and Wellness cannot control the use or further disclosure of your information once it has been released to the authorized recipient.

**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

\_\_\_\_ 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