Philadelphia Women's Center

777 Appletree Street, Seventh Floor • Philadelphia, PA 19106
215-574-3590 • 800-869-2330 • 215-574-3595 (Fax)

Medical Records Release

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

Patient Name: _____ DOB: _____

Phone number: _____

☐ check here if we cannot identify ourselves as PWC. ID as _____

I hereby authorize PW C 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

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)

☐ Copy of ultrasound(s) ☐ Proof of Depo Shot ☐ Proof of PACA ☐ Billing info
☐ Full copy of chart (*may be subject to a charge*) ☐ For Completion of FMLA paperwork ☐ Appointment note with restrictions
☐ Other (*please describe and be as specific as possible*):

_____

--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 _____

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:

Philadelphia Women's Center
Attn: Privacy Officer
777 Appletree St., 7th Floor
Philadelphia, PA 19106

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
Notes: