Advanced Wellness Solutions & Midwifery of Doylestown
54 East Oakland Avenue
Doylestown, PA 18901
Phone 215-348-4002 Fax 215-348-4910

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date request received:_____

Patient Address:_____

Date of Birth:_____ Patient Phone Number:_____

I authorize:_____

To release my medical records to: _____

Address and/or fax#/phone of the recipient or where my health information should be delivered:
_____

Specific information to be release:_____

Dates of service from_____to_____.

Specific purpose of release:_____
(Note: "at the request of patient" if the patient is initiating this Authorization)

HIV, Behavioral health, and Drug and Alcohol treatment contained in the parts of the record(s) indicated above will be released through this Authorization, Unless I request otherwise by checking here:_____

Exception: I do not give permission to release:_____

I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance there on, and that this consent will remain in force in order to effectuate the proposed or which it is given unless revoked by me.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

_____ _____ _____
Patient's Signature Date Signature of Witness

If individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness