Indiana University of Pennsylvania
Health Service, Suites on Maple East, Suite G-65
901 Maple Street, Indiana, PA 15705
Phone: (724) 357-2550 Fax: (724) 357-6212

AUTHORIZATION FOR RELEASE OF GYNECOLOGICAL INFORMATION

I hereby authorize:

Facility / Provider Name: _____

Address:_____

Phone#: (_____)_____ Fax #: _____

To disclose the medical information from the health records of:

Patient Name: _____
(PRINTED) Last First MI

Date of Birth: _____/_____/_____ Social Security #:_____ ID#: _____

Covering the period(s) of healthcare: From (date)_____ to (date)_____

Information to be disclosed:

- Last physician visit
- Any reactions to meds
- Weight
- Pregnancy testing
- Method of Birth Control
- Blood pressure
- PAP testing within 12 months is required
- Date of last Injection if on Depo-Provera
- STD Screens

I understand that this will include information relating to (check if applicable):

- ❑ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.

This information is to be disclosed to:

Facility / Provider Name: Health Service, IUP
Address: 901 Maple Street, Indiana, PA 15705
Phone#: (724) 357-2550 Fax #: (724) 357-6212

For the purpose of: Continuity of Care / Birth Control Administration

I understand that I can revoke this authorization at any time. I understand that I must do so in writing and present the revocation to the Medical Records Coordinator at IUP Health Service. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire on the following date, event or conditions_____. If I fail to specify expiration, event or condition, this authorization will expire in thirty days.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that if I refuse, the inability to review the information may disrupt continuity of care. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have any questions about disclosure of my health information I can contact Kim Kucinski, Medical Records Coordinator at 724-357-2550.

_____ _____
Signature of Patient or Legal Representative **(Date)**

_____ _____
If signed by Legal Representative, Relationship to Patient **Signature of Witness**