Divekar & Associates

Gynecology, Aesthetics & Wellness Center
9102 Babcock Blvd, Suite 107 Pittsburgh PA 15237
Tel: (412) 499-3540 Fax (412) 499 -3210

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize ___________________________________to release information from the record of:
Name of Facility/Person

___________________________________ __________________ ____________ to
Name of Patient Date of Birth SSN

___________________________________ __________________ ____________
Name of Facility/Person Phone Fax

____ ___________________________
Address of Facility/Person

For the purpose of **(PROVIDE A DETAILED DESCRIPTION)** _________________________________

Parts 1 and 2 must be completed to properly identify the records to be released

1. Type of records to be released and approximate date(s) of service (check all that apply)
   - ☐ Inpatient ☐ Emergency Dept Dates: ____________________________
   - ☐ Outpatient ☐ Physician Office/Clinic

I authorize the release (all that apply) ☐ Mental Health Information ☐ Drug and Alcohol Information, contained in the records indicated above.

2. Specific Information to be released (check all that apply)
   - ☐ Consults/Office Not ☐ Medical History & Physical Exam ☐ Emergency Dept. Report
   - ☐ Medication Records ☐ Laboratory and Radiology Reports ☐ Operative Report
   - ☐ Mammography Report ☐ Pathology Report
   - ☐ Other:____

HIV-related Information contained in the parts of the records Indicated above will be released through this authorization unless otherwise Indicated. ☐ Do not release

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: __________________________

_______________	______________________________	_________________	__________________
Date/Time of Signature	Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.	Date/Time of Signature	Signature of Patent, Legal Guardian or Authorized Representative (Complete Below)

_______________	______________________
Date/Time of Signature	Witness/Staff Member Signature