GyneSolo, P.C.

I hereby authorize_____**GyneSolo, P.C., Dr Diana P. Carmona-Keller** ___to release information from the record of:
Name & Phone Number of Facility/Person

_____ _____ _____ as described below to:
Patient Name Date Of Birth SSN/MR#

_____ _____ _____
Name of Facility/Person Phone Fax

GyneSolo, P.C. 400 Southpointe Boulevard; Suite 110 Canonsburg, PA 15317
Facility/Person Address

Records are requested for the purpose of (**PROVIDE A DETAILED DESCRIPTION**): _____

_____

Please complete both sections to ensure proper release of records.

Section 1: Type of records to be released and approximate date(s) of service

□ Inpatient Records: _____ □ Emergency Department: _____

□ Outpatient Records: _____ □ Physician Office/Clinic: _____

Section 2: Specific information to be released (check all that apply):

□ Consultation Report(s) □ Medical History and Physical Exam □ Physician Orders

□ Discharge Summary(s) □ Medication Administration Record □ Progress Notes

□ Laboratory Reports/Test(s) □ Operative Report(s) □ Psychiatric/Psychological Evaluation

□ Mammography Report(s) □ Pathology Report(s) □ Radiology Report(s)

□ Emergency Dept Report(s) □ EKG Report(s) □ Discharge Instructions

□ Other, specify: _____

_____

HIV, Mental Health and Drug & Alcohol Information in the parts of the records indicated above will be released as part of this authorization unless otherwise indicated Do Not release: □ HIV □ Mental Health (Psychiatric) □ Drug & Alcohol

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from 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 I authorized above to release the information. **(See opposite side for additional patient rights and responsibilities)**

If applicable, specify other expiration date/event here: _____

_____ _____ _____ _____
Date of Signature | Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment) | Date of Signature | Signature of Parent, Legal Guardian of Representative*

_____ _____
Date of Signature | Witness/Staff Member Signature Company

***Authorization Representative's Relationship and authority to act on behalf of named patient:** _____

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient mentioned above understood the nature of this release and freely gave their oral authorization.

_____ _____ _____ _____
Date of Signature | Witness # 1 Signature | Date of Signature | Witness # 2 Signature