

GyneSolo, P.C.

I hereby authorize _____ to release information from the record of:
Name & Phone Number of Facility/Person

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

GyneSolo, P.C., Dr Diana P. Carmona-Keller
Name of Facility/Person

(724) 916-0156
Phone

(724) 916-0157
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):

- | | | |
|---|--|---|
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Medical History and Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary(s) | <input type="checkbox"/> Medication Administration Record | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Reports/Test(s) | <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Psychiatric/Psychological Evaluation |
| <input type="checkbox"/> Mammography Report(s) | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Radiology Report(s) |
| <input type="checkbox"/> Emergency Dept Report(s) | <input type="checkbox"/> EKG Report(s) | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> 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*
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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
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