Bala Women's Health
Helene Koch, DO
Obstetrics & Gynecology

25 Bala Avenue
Suite 205
Bala Cynwyd, PA 19004

Prospective Authorization to Release Electronic Health Information

Patient Name: ______________________________ Date of Birth: ___/___/___

1. Consent for treatment:
   I authorize the physicians and staff of Bala Women's Health to assess my health care conditions and to provide care, services, clinical imaging, or other therapies necessary to effectively diagnose and treat me.
   I do NOT consent.
2. Authorization to Release Electronic Information:
   I authorize Bala Women's Health to electronically release information from my health record for the sole purpose of medical care to other health care providers or organization from which I may seek treatment and/ or to which I am referred by Bala Women's Health. This authorization is in effect unless revoked (see below).
   I do NOT authorize Bala Women's Health to electronically release information from my health record to other organizations or health care providers. I understand that I have the right to change this authorization at any time by completing and submitting a new *Prospective Authorization to Release Electronic Health Information* form.

Information to be released may include physician progress notes, current and historical information about diagnosis, problem list, medications and drug allergies, immunizations, laboratory and procedure test results, vitals, smoking status, care plan, clinical imaging, and demographics. This release does not authorize the use of patient information for purposes other than treatment, payment for medical services, and clinical practice operations.

Sensitive Information: **I understand that if I have been treated for AIDS/HIV, drugs or alcohol dependence, psychiatric, and/or reproductive health issues, my records may contain information about that treatment.** I understand that my records are protected under the Federal Privacy Act, P.L. 93-75, the Federal Alcohol and Drug Abuse Act, P. L. 92-282, the Pennsylvania Mental Health Procedures Act 197, and the Pennsylvania Confidentiality of HIV-Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise described in the regulations. **I understand that if I do not want these sensitive records shared, I should check the box under 2 (two) above "I do not authorize Bala Women's Health to electronically release information from my health record with other organizations or health care providers", and sign below.**

Right to Revoke this Authorization: I understand that I have the right to revoke this authorization in writing (except to the extent that Bala Women's Health has acted in reliance with this authorization). To revoke this authorization I may complete a new *Prospective Authorization to Release Electronic Health Information* form and submit it to my provider's office, or send a written request to our office through mail, fax, or email.

Patient Signature: ______________________________ Date: ___/___/___ Time: _______

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