Bala Cynwyd Women's Health
Helene Koch DO & Simone Holden PA-C
Obstetrics & Gynecology

25 Bala Avenue
Suite 205
Bala Cynwyd, PA 19004
610-667-6363

Authorization for Release of Medical Record Information

Patient Name: _____ Date of Birth: _____
Telephone: _____ Last 4 SSN: _____
Address: _____

I authorize Bala Women's Health to release my medical record information to:

Facility/Physician Name: _____
Address: _____
Telephone: _____Fax: _____

Dates and Type of Information to Disclose:
2 years prior from last date seen
Dates other: _____
Specific Information/Records Requested:

The Purpose of disclosure is:
Change of Physician or Insurance
Continuation of Care
Referral
Other_____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization if valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand that I may revoke this authorization at any time. I understand that if I revoke authorization I must do so in writing and present my written revocation to Bala Women's Health. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. I understand that there is no guarantee that my identifiable health information will not be re-disclosed by the above recipients.

I understand that authorizing the disclosure of this health information is voluntary; I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. This request for release of medical information is at my request. I understand this authorization will expire one (1) year from the date it is signed.

I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient: _____ Date: _____ Time: _____

If above not Patient but Authorized Representative or Guardian:

Printed name: _____ Relationship: _____

Phone: 610-667-6363
Fax: 610-667-5155
E- mail: balawomenshealth@gmail.com