Associates in Women's Health of the Mahoning Valley, Inc.

Obstetrics
Gynecology
Infertility

1350 Fifth Avenue • Suite 324 • Youngstown, OH 44504 • P: 330.746.7007 • 330.746.8818

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

I request and authorize _____ to release medical records of the above named patient to:

Name: **ASSOCIATES IN WOMEN'S HEALTH OF THE MAHONING VALLEY**

Address: **1350 FIFTH AVENUE, SUITE 324**

City: **YOUNGSTOWN** State: **OH** Zip: **44504**

Request and authorization applies to:

❍ Entire medical record including information regarding the treatment of psychological conditions, HIV testing and AIDS related conditions, alcohol and drug abuse and sexually transmitted diseases

❍ Other specific portions of the medical record

❍ Only pregnancy related information including laboratory reports, pathology reports and diagnostic imaging reports

❍ Only gynecological information including laboratory reports, pathology reports and diagnostic imaging reports

I, the undersigned, understand that i may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED