



Dedicated to Women
OB-GYN

200 Banning Street, Suite 320
Dover, DE 19904
Phone: (302) 674-0223
Fax: (302) 674-0109

209 E. Main St.
Middletown, DE 19709
Phone: (302) 389-4009
Fax: (302) 376-5205

Robert H. Radnich, MD, FACOG
Peter J. Wong, MD, FACOG
Robert Q. Scacheri, MD, FACOG
Robert B. Hartmann, Jr., MD, FACOG
Laura B. Moylan, MD, FACOG
Margaret R. Chou, MD, FACOG
Michelle H. Cooper, MD, FACOG
M. Scott Bovelsky, MD, FACOG
Jemine L. Wayman, CNM
Teresa A. Harris, RN, WHNP
Gayle A. Fosterling-Pearson, RN, WHNP

**HIPAA AUTHORIZATION FORM
For Medical Records to Be Released by Dedicated to Women OB-GYN**

INDIVIDUAL'S NAME (please print): _____ DATE OF BIRTH: _____

INDIVIDUAL'S ADDRESS _____ PHONE #(____)____-_____

I hereby authorize use or disclosure of protected health information about me as described below.

FROM: DEDICATED TO WOMEN OB-GYN (DTW)
200 BANNING STREET, SUITE 320, DOVER, DE 19904

TO: The following person (or class of persons) *may receive disclosure* of protected health information about me:
His/her/its name and address: _____
Phone: _____
Fax: _____

Please list below **the specific information and/or dates of service** that should be disclosed. We will routinely forward up to two years' medical history unless otherwise specified:

1. **YOU MUST SIGN BELOW** regarding DISCLOSURE OF INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH. If not signed, no such information will be sent.

i. YES, DISCLOSE THIS INFORMATION _____
Signature of Patient or Guardian

OR

ii. NO, DO NOT DISCLOSE THIS INFORMATION _____
Signature of Patient or Guardian

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
3. I may revoke this authorization by notifying DTW PRIVACY OFFICER in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. 1) You will receive an invoice from HealthPort for services rendered. Please direct any questions to HealthPort Customer Service Dept. at 800-367-1500.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that two signatures may required.

2) Fee schedule (as established by the State of Delaware) for patient requests for transfers or personal reasons: \$2.00 per page for pages 1-10, \$1.00 per page for pages 11-20, \$0.90 for pages 21-60, \$0.50 per page for pages 61 and above. There is an additional charge for postage.

3) Please allow 2-3 weeks for medical records to be processed and mailed to the specified address noted above.

Signature of Individual
(The person about whom the information relates)
If applicable –

Date of Individual's Signature

Date of Birth or Social Security Number

Signature of Guardian or
Personal Representative of Patient's Estate

Date of Guardian's/Personal
Representative's Signature

Description of Authority to Act for
the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.