

**Women's Institute for Gynecology & Minimally Invasive Surgery, LLC**  
**1600 Sixth Avenue, Suite #117**  
**York PA 17403**  
**(717) 840-9885**  
**(717) 840-9313 FAX**  
**Julie Drolet, MD, FRCSC, FACOG**  
**Jean Isherwood, CRNP**  
**Deborah Gobel, CRNP**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To received from / disclose to:** Women's Institute for Gynecology & Minimally Invasive Surgery, LLC  
Julie Drolet, MD  
1600 Sixth Avenue, Suite #117  
York PA 17403

Reason for transfer: \_\_\_\_\_

The following information for dates of service: \_\_\_\_\_

- |                                |                                    |
|--------------------------------|------------------------------------|
| _____ Complete medical history | _____ History/Physical examination |
| _____ Physicians Orders        | _____ Admission facesheet          |
| _____ Consultations            | _____ Operative reports            |
| _____ Discharge summary        | _____ Progress reports             |
| _____ X-ray/imaging reports    | _____ Laboratory reports           |
| _____ Other _____              |                                    |

The above is being requested for the purpose of **continuing care**.

This information is being disclosed to the above person, organization or agency from whose confidentiality may be protected by the Drug and Alcohol Act (Pennsylvania Law, Act 63) and/or the Medical Health Procedures Act (Pennsylvania R.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public law 93-282) and/or Confidentiality of HIV Related Information Act (Pennsylvania Law, Act 148). My signature below authorized release of all such information by routine, express mail service or facsimile transaction.

I understand that I have no obligations whatsoever to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information stated.

THIS AUTHORIZATION SHALL EXPIRE 30 DAYS FROM THE DATE SIGNED UNDER PENNSYLVANIA STATE LAW ACT 63. ALL OTHER AUTHORIZATIONS EXPIRE 6 MONTHS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED BY THE PATIENT.

\_\_\_\_\_  
Print patient's full name      Date

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Patient's date of birth

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient's social security number

\_\_\_\_\_  
Witness signature      Date