EXPANDED AUTHORIZATION TO RELEASE HEALTH INFORMATION Health information cannot be released until this form is completed, signed by a patient or legal guardian. Return to Medical Records or Fax: 609-924-3477. *Processing fee may be associated with this request*

MR#

I, _____ (PRINT NAME) Date of Birth _____, hereby request and authorize _____ (Name of Provider) to release my Protected Health Information (PHI), as specified below, to the following person(s) as my Authorized Agent(s):

Name: Penn Medicine Princeton Medical Physicians OBGYN Phone: 609-853-6555

Address: 5 Plainsboro Road Suite 500 Fax: 215-893-6798

City, State, Zip Code: Plainsboro, NJ 08536 Fax Mailbox: PMPM-PrincetonOBGYN@pennmedicine.upenn.edu

1. I authorize that the PHI that is available about me, be released to the Authorized Agent based on the specific request of the Authorized Agent.

   - The release of information authorized here specifically covers oral and e-mail communications between the Authorized Agent and the Provider. I understand that i*f I had prenatal/pregnancy care with PMG, my record will include HIV and Genetic test results (**please initial below).*
   - I understand that my healthcare provider or other covered entity cannot condition treatment, enrollment, payment or other benefits on the execution of this authorization.
   - I specifically authorize the release of the following **Sensitive information**: Please initial the space next to the special medical records you give us permission to release:

_____ Drug and Alcohol Abuse records

_____ Mental Health records

_____ Sexual Abuse/Adult & domestic violence records

_____ HIV/Aids record not related to pregnancy

_____ Sexually-Transmitted Disease records

_____ ***prenatal/pregnancy care with PMG, record will include HIV and Genetic test results**

2. This authorization for use/disclosure is for the following purposes: ☐ New provider needs them ☐ Personal ☐ Other reason _____
3. I understand that the information described above may be re-disclosed by the Authorized Agent and I know that my information may no longer be protected by Federal or State privacy regulations.
4. This authorization will remain effective for 180 days from the date it is signed or until such time that I send in my written request to have this authorization revoked.
5. I understand that I have the right to revoke this authorization, at any time, and that request must be in writing to the named provider. ***I understand that a revocation will be effective except to the extent that the Provider has already taken action in reliance on this authorization.***

Signature of Individual or Legal Representative **Printed Name** **Date**

Signature of Witness **Printed Name of Witness** **Date**