Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034
(856) 667-5910

MEDICAL RECORD RELEASE

Patient Name:_____Your Name________________ **DOB:**__Date of Birth__ **DOS:** Date of Procedure

I, ____Your Name_______, hereby authorize the Cherry Hill Women's Center to use or disclose the following protected health information:
(Specifically describe the information to be used, disclosed, including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)
Description of records that you need: "Copy of my full medical records" or "copy of doctor's note", etc.

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The protected health information may be disclosed to:

Your name and contact information or the name and contact information of the doctor or person to get your information.

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request.)*
At my request ____

This authorization shall be in force and effect until: (check one of the following) *Please leave this section blank. Clinic staff will fill in this section.*

Date_________________________

The happening of the following event: ____

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End of research study at which time this authorization to use or disclose this protected health information expires.

No expiration (can only be used if authorization is for creation of research database or research repository.)

I understand that as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034
Attn: Privacy Officer

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_Your signature________________________________ ____________________________
Signature of Patient or Personal Representative Date

(A copy of the signed authorization must be provided to the patient.)