



WOMEN'S HEALTH CARE GROUP OF PA
Main Line Perinatal Associates Division

Nancy S. Roberts, M.D. • Andrew G. Gerson, M.D. • Eric J. Carlson, D.O. • Alan E. Donnenfeld, M.D. • Sara S. Nicholas, M.D. • Antonette Dulay, M.D.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name (Printed): _____ Date of Birth: _____

1. By my signature below, I hereby authorize the disclosure of my protected health information including, but not limited to, results, prescriptions, and appointments to the person(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization ___ DOES / _____ DOES NOT INCLUDE disclosure of HIV status.

Signature: _____ Date: _____

2. By signing below, I hereby authorize the practice to leave my protected health information including, but not limited to, results, prescriptions, and appointments, on my answering machine/ voicemail.

Signature: _____ Date: _____

**PATIENT ACKNOWLEDGMENT OF RECEIPT OF WOMEN'S HEALTH CARE
GROUP OF PA'S NOTICE OF PRIVACY PRACTICES**

I acknowledge that Women's Healthcare Group of PA, LLC has provided to me information about the "Notice of Privacy Practices." I was given the opportunity to ask questions about the privacy practices and my questions were answered. I received a copy of the "Notice of Privacy Practices."

Signature: _____ Date: _____

Name (Printed): _____

Witness: _____ Date: _____