

Authorization for Release of Protected Health Information

Allegheny General Hospital
320 East North Avenue
Pittsburgh, Pennsylvania 15212-4772

Allegheny General Hospital-
Suburban Campus
100 South Jackson Avenue
Pittsburgh, Pennsylvania 15202

Fax
412-359-3819

Patient Name: _____

Date of Birth: _____

IMPRINT PATIENT'S PLATE HERE

TO: Allegheny General Hospital (AGH) or _____

I have been a patient at Allegheny General Hospital, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____ (name of patient or legally authorized representative) hereby authorize the AGH Medical Records Department or _____ to release to:

(Name of Individual, Facility, Agency, School, or Entity to Receive Health Information)

(Street Address)

(City, State)

(Zip Code)

(Phone No.)

The following information or copies of: (place a check by types of records desired)

Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, Discharge Summary, ER Report)

Discharge Summary

Operative Reports

Consultation

H&P

Progress Notes

Radiology (x-ray, CT, MRI, etc.)

Lab Results

Emergency Department

Outpatient/Clinic (specify) _____

The above information and/or the entire Clinical Record which includes HIV-Related Information.

The above information and/or the entire Clinical Record including mental health, drug or alcohol treatment

Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment

Billing or other business records (specify): _____

Other (specify): _____

from (date): _____ to (date): _____

at: AGH AGH-SC Physician Office _____ (specify) Other Facility _____ (specify)

Reason for Request:

Employer

Continuing treatment

Study/Research

Insurance

Legal

Other _____

Second Opinion

I do not wish to disclose the reason

This authorization will expire in six months or: _____ (specify expiration date, event or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the AGH Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

Patient or Representative Signature

Date

Witness

Date

(when required by policy or signing by mark)

If representative, give relationship and authority to act: _____