GENESIS MEDICAL ASSOCIATES, Bentz, Grob, Scheri and Woodburn Family Medicine
1140 Perry Highway, Pittsburgh, Pa 15237
Phone 412-364-4402 Fax 412-364-3850

Authorization for Disclosure of Health Information

PLEASE MAIL RECORDS. DO NOT FAX.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations, and that it may be redisclosed by the recipient.

I, _____ _____
Name of Patient (please print) Date of Birth

Authorize: _____ To disclose to: Bentz, Grob, Scheri, &
_____ Woodburn Family Medicine
_____ 1140 Perry Highway
_____ Pittsburgh, Pa 15237

Release the following information from the above named patient's healthcare records

_____Complete health records _____History _____X-ray reports
_____Progress notes _____Physical exam _____MRI reports
_____Laboratory results _____Other (specify)_____

The above requested information may include HIV (AIDS) Diagnosis/Treatment records, Mental Health Diagnosis/Treatment records, and alcohol and/or drug abuse Diagnosis/Treatment records if included in my medical record.

This disclosure is being made for the following purpose(s):

_____Continuing care _____Insurance _____Attorney _____Work comp
_____Personal reasons _____Transfer of care _____Other: _____

1. I understand this authorization will expire on_____(date) or at the time of the following event: _____
   Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying Drs' Bentz, Grob, Scheri, and Woodburn in writing, but if I do, it will not have any effect on any actions that were taken before they received the revocation.
   Initials: _____

The facility, its employees, officers, and physicians are hereby released from any legal liability for the disclosure of the above information to the extent indicated and authorized therein.

Patient Signature _____ Date _____
Signature of Parent or Legal Representative _____

You can refuse to sign this authorization. We cannot condition treatment on your signing this authorization.