



MRN: _____

Central Outreach Wellness Center

Aliquippa	Erie	Pittsburgh	Washington	Cleveland	Columbus	Harrisburg
Location: Pittsburgh, PA - 127 Anderson St. #101, 15212 Contact us: (412) 515-0000 F: (877) 245-1644						

**Authorization for Release of Information
to Release Records (HIPAA)**

Patient Name: _____ DOB: _____ SSN#: _____

Address: _____ Zip Code: _____

I hereby authorize:

Central Outreach Wellness Center
127 Anderson Street, Suite 101, Pittsburgh, PA 15212
to release my medical information to:

Facility Name: _____

Address: _____ Zip Code: _____

Phone: _____ Fax: _____

(All parts below must be completed to properly identify the records to **RELEASE**).Please complete a release **PER** location if you need your records to be released to multiple locations.from the approximate dates of service: From _____ To _____ or ☐ Complete Record

for the purpose of: (Please Check Only One)

☐ Continuing Care/ Medical Facility☐ Legal☐ Personal Use☐ Insurance☐ OTHER: _____**I authorize the release of:** (check all that apply):
contained in the records indicated below.☐ Mental Health ☐ Drug/Alcohol ☐ HIV
☐ Other _____**1. Type of records to be released (check all that apply):**☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Physician Office/Clinic ☐ OTHER: _____**2. Specific information to be released (check all that apply):**

☐ Consult reports	☐ Medical History & Physical Exam	☐ Physicians Orders	☐ Medications
☐ Discharge Summary	☐ Laboratory Results / Tests	☐ Physicians Notes	☐ Operative Report
☐ Nursing Notes	☐ Psychiatric Evaluation	☐ Pathology Report	☐ Radiology Report
☐ EKG Report	☐ Emergency Dept. Report	☐ Rehabilitation Report	☐ Entire Medical Record
☐ OTHER: _____			

I understand that this authorization is effective for 1 period of 1 year from the date of signature, unless otherwise specified below. understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date here: _____.

I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary.

I need not sign this form to ensure healthcare treatment, in accordance with 4 Pa Code 255.5 (b). Drug and Alcohol treatment information to be released to judges, Probation or parole officer, insurance companies, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment; 2) the progress of the client; 3) The nature of the program; 4) A brief description of the progress of the client; 5) A short statement as to whether the client has relapsed into drug and alcohol abuse and the frequency of such relapse.

Signature of Patient: _____ Date: _____

The Patient has given verbal authorization to release the above information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives their consent.

Signature of Witness: _____ Date: _____

Signature of Witness: _____ Date: _____



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**Authorization for Release of Information
to Obtain Records (HIPAA)**

Patient Name: _____ DOB: _____ SSN#: _____

Address: _____ Zip Code: _____

I hereby authorize:

Facility Name: _____

Address: _____ Zip Code: _____

Phone: _____ Fax: _____

To disclose my medical information to:

Central Outreach Wellness Center**127 Anderson Street, Suite 101, Pittsburgh, PA 15212**(All parts below must be completed to properly identify the records to **OBTAIN**).Please complete a release **PER** location if you need your records to be obtained from multiple locations.from the approximate dates of service: From _____ To _____ or ☐ Complete Record

for the purpose of: (Please Check Only One)

☐ Continuing Care/ Medical Facility☐ Legal☐ Personal Use☐ Insurance☐ OTHER: _____**I authorize the obtaining of:** (check all that apply):
contained in the records indicated below.☐ Mental Health ☐ Drug/Alcohol ☐ HIV☐ Other _____**1. Type of records to be obtained (check all that apply):**☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Physician Office/Clinic ☐ OTHER: _____**2. Specific information to be released (check all that apply):**

☐ Consult reports	☐ Medical History & Physical Exam	☐ Physicians Orders	☐ Medications
☐ Discharge Summary	☐ Laboratory Results / Tests	☐ Physicians Notes	☐ Operative Report
☐ Nursing Notes	☐ Psychiatric Evaluation	☐ Pathology Report	☐ Radiology Report
☐ EKG Report	☐ Emergency Dept. Report	☐ Rehabilitation Report	☐ Entire Medical Record
☐ OTHER: _____			

I understand that this authorization is effective for 1 period of 1 year from the date of signature, unless otherwise specified below. understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to obtain the information. If applicable, specify other expiration date here: _____.

I understand that the revocation will not apply to information that has already been obtained in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary.

I need not sign this form to ensure healthcare treatment, in accordance with 4 Pa Code 255.5 (b). Drug and Alcohol treatment information to be released to judges, Probation or parole officer, insurance companies, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment; 2) the progress of the client; 3) The nature of the program; 4) A brief description of the progress of the client; 5) A short statement as to whether the client has relapsed into drug and alcohol abuse and the frequency of such relapse.

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