Medical Records Request

Patient Name:_____
Last First MI (Maiden Name or Other Name)

Date of Birth:____-____-____ SS#____-____-____ Day Phone:(____)_____-_____ Evening Phone(____)_____-_____

Address:_____City_____State_____Zip_____

I hereby authorize_____(Name of Provider) to release information from my medical record as indicated below to:

Name: PITTSBURGH FOOT AND HAND CENTER / MICHAEL W. BOWMAN MD

Address 20130 RT 19 SUITE 1100 City CRANBERRY TWP State PA Zip 16066

Phone: 724-933-3300 Fax 724-933-3332

Information to be released:

		Dates:
☐	History and Physical Exam	_____
☐	Progress Notes	_____
☐	Lab Reports	_____
☐	X-Ray / Test	_____
☐	Operative Report	_____
☐	Other _____	_____

I Specifically authorize the release of information relating to:

- ☐ Substance abuse (including drug/alcohol)
- ☐ Mental Health (including Psychotherapy)
- ☐ HIV related info (AIDS related testing)

Signature:_____ Date_____

Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Consult / Second Opinion
- ☐ Continuing Care
- ☐ Workers Compensation
- ☐ Legal
- ☐ School
- ☐ Insurance
- ☐ Other Please Specify_____

1. I understand that this authorization will expire 90 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that the information used or disclosed pursuant to this authorization may subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am begin requested to release this information _____ (print name of provider) for the purpose of: _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this for if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that _____(print name of provider) ☐will / ☐will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with PA statute, I will pay a fee of $_____. There is no charge for medical records if copies are sent to a facility for ongoing care of follow-up treatment.

_____ _____ or _____ _____
Signature of Patient Date Parent / legal Guardian Date

Records Received by:_____ Date_____Relationship Patient_____

Date request filled_____By:_____-Fee_____