Shadyside Cardiovascular, PLLC

Authorization for Release of Protected Health Information

Patient Name:_____
Last Initial First

Date of Birth (XX/XX/XXXX):_____ Last Four (4) Digits of Patient's SSN:_____

Address:_____

_____

Phone Number:_____ Fax Number:_____

I hereby authorize the following person(s) or entity to release my Protected Health Information (PHI):

Name of Provider: _____
Street Address: _____
City, State Zip Code: _____
Phone and Fax: _____

Please choose who will receive the information and the method of delivery. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

- ☐ To me. Please deliver by U.S. Mail to my personal address. (Records will be mailed to address listed above.)
- ☐ To me. I prefer to pick up my records personally. Please call me when they are ready. (Photo ID will be required for pick up.)
- ☐ To the following person or entity:

_____
Name of individual, medical office, company/entity you want to receive the records

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number Fax Number

The Protected Health Information (PHI) or copies of I would like to have released is as follows:

- ☐ Release an abstract of my PHI (two(2) year summary) (I understand that information may include acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease unless otherwise indicated

  Do not release: ☐ AIDs/HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol
- ☐ Other (specifically identify exact information to be disclosed, including specific dates of service):

_____
_____
_____

The purpose of my request is:

□ Continuing Treatment □ Legal □ Employer □ Personal Use

□ Insurance □ Study/Research □ Other: _____

I understand that this authorization shall expire one (1) year from the date of signature unless otherwise specified below. Expiration date may not exceed one year from the date of signature. If applicable, specify other expiration date/event here: _____.

I understand that I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.

I understand that I am not required to sign this Authorization as condition of my obtaining treatment.

I understand that, to the extent that any Recipient of this information, as identified above, is not a "covered entity" under Federal Law, the information may no longer be protected by federal and state law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.

I am entitled to a copy of this completed Authorization upon my request.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Authorized Representative* Date

_____ _____
Witness/Staff Member Signature Date

If signed by an Authorized Representative, complete the following:

Printed Named of Personal Representative: _____

Description of Authority to Act for Individual: _____

_____

(If you have not already provided us with the appropriate legal documents supporting your personal representative status, please submit these documents with the form.)

ORAL AUTHORIZATION

Only to be used if the patient is physically unable to sign. This is NOT applicable to HIV related information or Drug & Alcohol Treatment.

I witness that the nature of this release has been explained to the patient, that the patient understood the nature of the release and freely gave oral authorization. (Two witnesses are required)

Witness: _____ Witness: _____
Date: _____ Date: _____