Authorization For the Release of Protected Health Information

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that the information released by the person/organization authorized below may possibly be re-disclosed by the person/organization that receives the records and therefore its staff/employees have no responsibility or liability as a result of the re-disclosure and that such information may no longer be protected by federal privacy regulations or state law.

Patient Name:

_____

Patient Address:

_____

_____

_____Patient Telephone Number:

_____

Patient Date of Birth:

_____

Person/organization authorized **to provide** the information (e.g. Name, address, telephone, etc.):

_____

_____

_____

_____

_____Person/organization authorized **to receive** the information (e.g. Name, address, telephone, etc.):

Pittsburgh Health Partners
30 High Street
Pittsburgh, PA 15223
PH (412)782-6800 Fax (412)781-2123

_____Description of information to be released: **ONLY SEND THE LAST 2 YEARS OF RECORDS IF NOT SPECIFIED**

_____

_____

The protected health information will be used and/or disclosed for the following purposes: Please check the appropriate box.

□ At the request of the individual

□ Transferring to new provider

□ Moving out of the area

□ Other,
explain_____
_____

I understand that this authorization is valid for 90 days starting on
_____ and expiring on
_____.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility of benefits, except if authorization is needed for receiving research related treatment or for treatment solely for the purpose of creating health information for another party (for example, a pre-employment physical).

Signature of patient (or patient's representative)
_____

Date:
_____
_____

Printed name of patient's representative:
_____

Relationship to the patient:
_____