Thomas F. Carmen, M.D. & Associates
family practice & instant care

THOMAS F. CARMEN, M.D.AND ASSOCIATES
Village at Pine 1500 Village Run Road, Suite 308 Wexford, PA 15090
Telephone: 724-934-1900 Fax: 724-934-3388

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION
Read entire document before signing
This authorization gives permission to use or disclose health information about you.

Patient Name: _____ Date of Birth:____/_____/_____

1. **Source:** The following individual(s) or organization(s) are authorized to disclose the health information of the above named individual as described in this authorization.

_____
(Name of Previous Physician/Hospital/Insurance Company/Other)

_____
(Address)

_____
(Phone) (Fax)

2. **User/ Recipient:** The covered health information may be used or disclosed to
THOMAS F. CARMEN, M.D. AND ASSOCIATES

3. **Covered Health Information:** The following health information is covered by this authorization (except as limited below)

- ☐ Complete medical record
- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization Records
- ☐ Most recent history/diagnosis
- ☐ Discharge summary for admission on _____
- ☐ Lab results (Please list specific tests and dates below.)
- ☐ X-ray and imaging reports (please list specific studies and dates below.)
- ☐ Consultation report (Please supply consulting physician's name and date below.)
- ☐ Operative report: Procedure_____ Date____/_____/_____
- ☐ Progress note(s): Date___/____/_____ or Range of Dates_____
- ☐ Treatment Plan
- ☐ Other_____

Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. **Specifically protected information:** The following information is specifically protected by state and/or federal law. Please indicate below whether you would like the following information to be released.

Substance abuse records (drug or alcohol)	Yes ☐	No ☐	Initials _____
Mental health records protected by the Mental Health Procedures Act	Yes ☐	No ☐	Initials _____
HIV/AIDS related information	Yes ☐	No ☐	Initials _____

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5. **Other restrictions:** Please specify any other restrictions on the covered information:_____

6. **Purpose:** I am requesting use or disclosure of the covered health information for the following purpose:
   - ☐ My personal use
   - ☐ Further medical treatment
   - ☐ Insurance eligibility or benefits
   - ☐ Eligibility for disability benefits
   - ☐ Legal investigation or action
   - ☐ Other (please describe) _____

7. I understand that I have the following rights:
   - **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by THOMAS F. CARMEN, M.D. AND ASSOCIATES, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
   - **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation.
   - **Re-disclosure.** I understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

8. **Expiration.** This authorization expires as of the following date or event
   _____

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of patient (or personal representative) Date

Personal Representative Information (as applicable):

_____ _____
Name of Personal Representative Relationship to patient