| Michelle Harvison, M.D. | Stephanie Shaw Brown, M.D. |
Mary J. Sims, M.D. | Kristen E. Peske, D.O. | Amy B. Turner, D.O. | Karrah Dattilo, D.O. |
Julianne Capozzi-Ryan, D.O. |

Board Certified | Obstetrics and Gynecology
Phone 724-941-1866 | Fax 724-941-1647

St. Clair Outpatient Center
3928 Washington Road
Suite 230
McMurray, PA 15317

ADVANCED
WOMEN'S CARE OF PITTSBURGH, P.C.

Caste Village Office
5301 Grove Road
Pittsburgh, PA 15236

St Clair Health Office
1000 Bower Hill Road
Suite 213
Pittsburgh, PA 15243

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

NAME_____DATE OF BIRTH_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ PHONE NUMBER_____

I HEREBY AUTHORIZE ADVANCED WOMEN'S CARE OF PITTSBURGH, PC TO:

Obtain Records From:	**Release Records To:**
Name:	Name:
Address:	Address:
Phone: Fax:	Phone: Fax:

INFORMATION TO BE RELEASED/OBTAINED: (PLEASE CHECK MARK)

___ ENTIRE RECORD ___ PROGRESS NOTE(S) FROM _____ TO _____
LAB RESULTS FROM _____TO_____
___MEDICAL IMAGING FROM _____ TO _____
___CONSULTATION REPORTS FROM _____ TO_____

RECORDS ARE BEING REQUESTED FOR THE PURPOSE OF. PLEASE CHECK ONE

LEAVING PRACTICE____, PRIMARY CARE PHYSICIAN____, MOVING OUT OF STATE____,
SECOND OPTION____, FOR AN ATTORNEY/LEGAL REASONS____, INSURANCE____,SPECIALIST____

PLEASE PROVIDE A DETAILED REASON FOR REQUEST

_____

● I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASES: AIDS OR HIV. IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.
● I MAY REVOKE THE AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN NOTICE OF REVOCATION, I UNDERSTAND THIS NOTICE CANNOT BE REVOKED IF RECORDS HAVE ALREADY BEEN RELEASED.
● I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE BY THE RECIPIENT AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.
● I MAY REFUSE TO SIGN THIS AUTHORIZATION. MY REFUSAL WILL NOT AFFECT MY TREATMENT OR PAYMENT FOR MY CARE.
● IN THE CASE OF A MINOR CHILD: I CERTIFY THAT NO COURT ORDER IS CURRENTLY IN FORCE THAT WOULD PROHIBIT MY ACCESS TO THESE RECORDS OR PROHIBIT MY POWER TO CONSENT UPON ANOTHER PERSON.
● IN THE CASE OF A DECEASED PATIENT: I, UNDERSIGNED NEXT OF KIN, CERTIFY THAT I ASSUME RESPONSIBILITY FOR THE DISPOSITION OF THE BODY OF THE DECEASED. THERE HAS BEEN NO PROBATE OF THE DECEDENT'S ESTATE AND THERE IS NO INTENT TO ENTER THE ESTATE INTO PROBATE. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: (WILL AUTOMATICALLY EXPIRE 6 MONTHS FROM THE DATE OF THE PATIENT'S OR PERSONAL REPRESENTATIVE'S SIGNATURE.)

DATE_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE_____

PRINTED NAME OF PATIENT/ PERSONAL REPRESENTATIVE_____
RELATIONSHIP TO PATIENT_____

WE DO NOT TAKE CD'S WE ONLY TAKE FAXES AND PAPER COPIES