| Douglas H. MacKay, M.D. | Michelle Harvison, M.D. | Stephanie Shaw Brown, M.D. |
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3928 Washington Road
Suite 230
McMurray, PA 15317

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

Caste Village Office
5301 Grove Road
Pittsburgh, PA 15236

## 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 PHYSICAN____, 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**