2000 Cliff Mine Rd., Park West #2, Suite 110
Pittsburgh, PA 15275
(P) 412-494-4550 (F) 412-494-4551

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ALLEGHENY MEDICAL

I, _____, _____, do hereby consent to authorize
(Printed patient name) (Date of birth)

Allegheny Medical 2000 Cliff Mine Rd.,Park West Two,Suite 110, Pittsburgh Pa. 15271
(Person/Organization) (Address, City, State, Zip)

to release information requested to _____. Please include the following dates of treatment:

_____ to _____.
(Specific dates of treatment)

Check type of information to be released: ☐ Entire record

☐ Lab results ☐ Behavioral health ☐ X-ray results ☐ Diagnostic reports ☐ HIV

☐ STD ☐ Substance Abuse ☐ Other_____

The purpose for the disclosure of these records is: _____.

These records will be mailed to: _____
Name and address where records are being sent

_____

I understand that my signing this authorization will have no effect on my rights and responsibilities relating to my treatment, payment enrollment, or eligibility for benefits at Allegheny Medical, P.C. I understand that I might be releasing to the person/organization identified above, information which is specially protected under provisions of state and/or federal law. I also understand that there is a potential for my protected health information to be redisclosed by the recipient of the information. I further understand that I may revoke this authorization at any time except to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. To revoke this authorization, I must advise Allegheny Medical, P.C. in writing at the above address or facsimile number of my revocation. I further understand that, if not revoked earlier, this consent will remain in force for 1 year.

_____ _____
(Patient Signature) (Date)

_____ _____
(Witness Signature) (Date)

_____ _____
(Parent/Legal Guardian/Authorized Representative Signature) (Date)