PREMIER
MEDICAL ASSOCIATES
A Member of
Allegheny
Health Network

Patient Name: _____ Date of Birth: _____

Address: _____

To:
I have been a patient at your facility, or am the patient's authorized representative. I understand that the facility has legally protect-ed health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

I, _____ hereby authorize the facility to release to:

_____
(Name of Individual, Facility, Agency, School, or Entity to Receive Health Information)

_____
(Street Address)

_____
(City, State) (Zip Code) (Phone No.)

The following information or copies of: (place a check by types of records desired)

☐ Pertinent Documents (Face Sheet, Attestation, H&P, Consultations, Lab / Test Results, EKG's, OR Reports, Discharge Summary, ER Report)

☐ Discharge Summary ☐ Operative Reports ☐ Consultation ☐ H&P
☐ Progress Notes ☐ Radiology (x-ray, CT, MRI, etc.) ☐ Lab Results
☐ Emergency Department _____ ☐ Outpatient / Clinic *(specify)* _____

☐ The above information and / or the entire Clinical Record INCLUDING HIV-related information, mental health, drug or alcohol treatment

☐ Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment
☐ Billing or other business records *(specify):* _____
☐ Other *(specify):* _____

from *(date):* _____ to *(date):* _____

Reason for Request:

☐ Continuing treatment ☐ Employer ☐ Insurance ☐ Study / Research ☐ Legal ☐ Disability
☐ I do not wish to disclose the reason
☐ Other

This authorization will expire in six months or: _____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

I understand that this authorization is subject to revocation at any time, except to the extent that Premier Medical Associates/ Allegheny Health Network has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive and the information will no longer be protected by federal privacy regulations.

Patient or Representative Signature _____ Date _____ Time _____

If representative, give relationship and authority to act _____

Witness Signature _____ Date _____ Time _____

☐ Copy accepted ☐ Copy refused