

Alleghenies Independent Physicians
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of _____;
Patient Name
_____; _____ as described below to _____
Birth Date SSN/MR# _____

Records released from: Facility: _____
Address: _____

Records are requested for the purpose of **(Provide A Detailed Description):**

The records to be released (identify all that apply) are **(please include approximate dates of service):**

____ Inpatient Records; Dates: _____; ____ Emergency Room Records; Dates: _____;
____ Outpatient Records; Dates: _____; ____ Physician Office/Clinic; Dates: _____

- | | | |
|--------------------------------------|-------------------------------|-------------------------------------|
| ____ Medical History & Physical Exam | ____ Progress Notes | ____ Psychiatric/Psychological Eval |
| ____ Discharge Summary/Instructions | ____ Laboratory Reports/Tests | ____ Operative Report |
| ____ Pathology | ____ Medication Records | ____ Other (specify): _____ |
| ____ Consults | ____ Radiology | _____ |
| ____ Physician Orders | ____ Mammography Report | _____ |

HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated. Do not release: HIV Behavioral Health (Psychiatric) Drug & Alcohol

I understand the following:

- That my health record(s) will not be released or obtained by Alleghenies Pulmonary Associates unless permission is provided herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by Alleghenies Pulmonary Associates may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Alleghenies Pulmonary Associates and staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to _____ at the following
(facility/person)
Address: _____
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke this Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.

