Patient Name: _____ Date of Birth: _____

TO: **The Western Pennsylvania Hospital – Forbes Regional Campus (WPH-FRC) or** _____

I have been a patient at The Western Pennsylvania Hospital - Forbes Regional Campus, or am the patient's authorized representative. I understand that the facility has legally protected 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.

I, _____ hereby authorize the
(Name of Patient or Legally Authorized Representative)

WPH-FRC Medical Records Department or _____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 Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, D/C Summary, ED 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 which includes HIV-Related Information
The above information and/or the entire Clinical Record including mental health, drug or alcohol treatment
Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment
Billing records (*specify*) _____
Other (*specify*): _____

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

at: WPH-FRC Physician Office _____ Other Facility _____
(*specify*) (*specify*)

Reason for Request: Continuing treatment Insurance Legal
Employer Study/Research Second Opinion
Other _____ **I do not wish to disclose the reason**

This authorization will expire in six months or: _____
(Specify expiration date, event or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to the extent that The Western Pennsylvania Hospital - Forbes Regional Campus 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 WPH-FRC Privacy Officer. I understand that recipients may redisclose information that I have authorized them to receive.

_____ _____
Patient or Representative Signature Date Witness Date
(*when required by policy or signing by mark*)
_____ Copy accepted Copy refused
If representative, give relationship and authority to act

Addressograph

THE WESTERN PENNSYLVANIA HOSPITAL
FORBES REGIONAL CAMPUS
WEST PENN ALLEGHENY HEALTH SYSTEM

2570 Haymaker Road
Monroeville, PA 15146

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION
07/20/05