

# Authorization for Release of Protected Health Information

Allegheny General Hospital  
320 East North Avenue  
Pittsburgh, Pennsylvania 15212-4772

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

IMPRINT PATIENT'S PLATE HERE

TO: Allegheny General Hospital (AGH) or \_\_\_\_\_

I have been a patient at Allegheny General Hospital, 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, \_\_\_\_\_ (name of patient or legally authorized representative) hereby authorize the AGH 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, Discharge Summary, ER Report)

Discharge Summary

Operative Reports

Consultation

H&P

Progress Notes

Radiology (x-ray, CT, MRI, etc.)

Lab Results

Photographs

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 or other business records (specify): \_\_\_\_\_

Other (specify): \_\_\_\_\_

from (date): \_\_\_\_\_ to (date): \_\_\_\_\_

at:  AGH  Physician Office \_\_\_\_\_ (specify)  Other Facility \_\_\_\_\_ (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 Allegheny General Hospital 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 AGH Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

(when required by policy or signing by mark)

If representative, give relationship and authority to act \_\_\_\_\_