

**Authorization for Release
of Protected Health Information**

Alle-Kiski Medical Center
Allegheny Valley Hospital
Citizens Ambulatory Care Center
1301 Carlisle Street
Natrona Heights, PA 15065



Patient Label

768-018 Rev. 11/03

MR # _____

Patient Name: _____ Birthdate: _____

TO: Alle-Kiski Medical Center

I have been a patient at Alle-Kiski Medical Center, 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.

Release To/ Obtain From I, _____ (name of patient or legally authorized representative) hereby authorize the Alle-Kiski Medical Center Medical Records Department to release to or obtain from:

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

(Street Address)

(City, State)

(Zip Code)

(Phone No.)

Information To Be Released

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

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: AVH CACC NKUCC CGH

For The Purpose of

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 Alle-Kiski Medical Center 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 AKMC 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 _____

Copy accepted Copy refused