

**CANONSBURG GENERAL HOSPITAL  
CANONSBURG, PENNSYLVANIA**

**Authorization for Release of  
Protected Health Information**

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

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

TO: Canonsburg General Hospital (CGH) or \_\_\_\_\_.

I have been a patient at a West Penn Allegheny Health System facility, 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 this form will not affect treatment I receive in any way.

I, \_\_\_\_\_ hereby authorize the CGH Medical Records Department or  
(Name of patient or legally authorized representative)

\_\_\_\_\_ to release to:

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

\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

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

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

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): \_\_\_\_\_

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 90 days. \_\_\_\_\_

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 West Penn Allegheny Health System 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 CGH 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