Patient Name: ______________________ Date of Birth: ______________________

TO: **Forbes Regional Hospital (FRH) or** ______________________

I have been a patient at Forbes Regional 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, ______________________ hereby authorize the
(Name of Patient or Legally Authorized Representative)

FRH 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, 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: ❑ FRH ❑ 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 Forbes Regional 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 FRH 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

2570 Haymaker Road
Monroeville, PA 15146

(Addressograph)

Authorization for Release of Protected Health Information

FRH-80 Rev. 8/11