

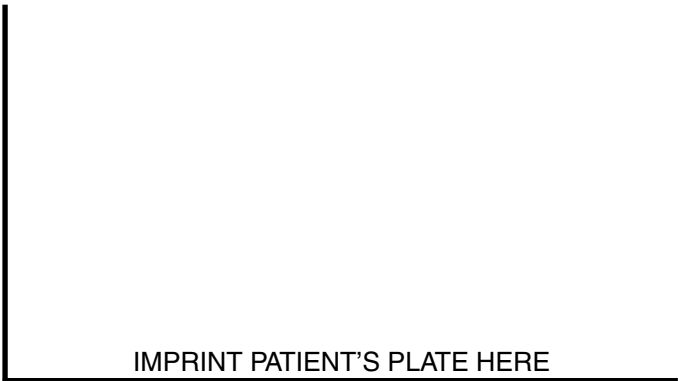
**Authorization for Release of Protected Health Information**

The Western Pennsylvania Hospital  
4800 Friendship Avenue  
Pittsburgh, Pennsylvania 15224



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

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



IMPRINT PATIENT'S PLATE HERE

TO: **The Western Pennsylvania Hospital (WPH)** or \_\_\_\_\_

I have been a patient at The Western Pennsylvania 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)

WPH 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
- 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:  WPH     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 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 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