Authorization for Release of Protected Health Information

I hereby authorize **Allegheny Reproductive Health Center, Inc.** to release information

FROM the record of:

Patient Name_____
DOB_____SS#_____
Address_____
_____
Telephone #_____

TO:

Facility/person_____
Address _____
_____
Telephone #_____
FAX # _____

For the specific purpose of:
____continued care ____personal ____legal other: _____

Method of Release/Disclosure:
____Fax ____Mail ____Patient will pick up ____Verbal only

Provide Date(s) of Service (approximate, if unknown) _____

Information to be released:
____ History/Physical Exam ____Ultrasound report ____ Medication Administration

____ Discharge summary ____ Operative Report ____ Lab Results ____ Progress Notes
Other, specify_____

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, in **writing**, except to the extent that ARHC may have already relied upon it in making a use or disclosure. My written revocation will become effective upon ARHC having knowledge of it.

This authorization is **limited** to the **purpose** and to the facility/person listed above and will be in **effect for 90 days** from the date of my signature unless otherwise specified. This authorization will expire on the following date _____.

Patient signature _____Date_____

Witness signature _____Date_____

I **understand** that information released by ARHC under this authorization may be re-disclosed by the receiving party, therefore ARHC and its staff/employees have no responsibility or liability as a result of a re-disclosure; as such, the released information is no longer protected by the Privacy Rule. I **understand** that ARHC cannot require me to sign this authorization as a condition to receive treatment. I **understand** that I am entitled to a copy of this completed Authorization form.

Please initial to confirm you have read the above and fully understand the content. _____