

**Allegheny Reproductive Health Center
1529 Kirkwood Street Pittsburgh PA 15206
Phone 412-661-8811 Fax 412-363-6901**

Authorization for **USE/DISCLOSURE** of Protected Health Information

I hereby authorize _____ to release information
(Name of facility, entity, practitioner)

FROM the record of:

Release/Disclose Information **TO:**

Patient Name _____
DOB _____ SS# _____
Address _____
_____ telephone # _____

_____ Address _____
_____ telephone # _____
_____ FAX # _____

For the specific purpose of:

continued care _____ personal _____ legal _____ other: _____

Method of Release/Disclosure:

Fax _____ Mail _____ Verbal only _____ Patient will pick up _____ Email *(see back)

Please check **type of record:** _____ Inpatient _____ Outpatient _____ Emergency _____ Physician office/clinic
Provide date(s) of treatment (approximate, if unknown) _____

The information to be released is:

_____ Most recent Pap results _____ History/Physical Examination _____ Ultrasound report
_____ Discharge summary _____ Operative Report _____ Lab tests
_____ Medication Administration _____ Progress Notes

Other: _____

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 person listed above and will be in **effect for 90 days** after 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, and therefore ARHC and its employees have no responsibility or liability as a result of and re-disclosure; as such, the released information is no longer protected by the Privacy Rule. I **understand** that ARHC cannot make me sign this authorization as a condition to receive treatment. I **understand** that I am entitled to a completed copy of this Authorization for Use/Disclosure form.

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

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***EMAIL CONSENT**

HIPAA stands for the Health Insurance Portability and Accountability Act, and was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information. Most popular email services (Ex. Gmail, Hotmail, etc.) do not utilize encrypted email. When ARHC sends you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to intercept the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

I understand the risks of unencrypted email and do hereby give permission to ARHC to send me personal health information via unencrypted email.

Patient signature _____

Patient email address _____

Date _____