

**SQUIRREL HILL HEALTH CENTER (SHHC)
AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

I hereby authorize _____ to release information from the record of

(Name of Medical Facility/Doctor)

(Fax Number of Releasing Facility)

(Phone Number of Releasing Facility)

_____; _____; _____
Patient Name Birth Date SSN#

as described below to:

Squirrel Hill Health Center
200 JHF Drive
Pittsburgh, PA 15217
Phone: (412) 422-7442
FAX: (412) 904-5025

<input type="checkbox"/> Last 3 visit notes	<input type="checkbox"/> Medication List	<input type="checkbox"/> Problem List	<input type="checkbox"/> Immunization List
<input type="checkbox"/> Most recent Pap report	<input type="checkbox"/> Most recent mammogram	<input type="checkbox"/> Last 6 months of lab results	
<input type="checkbox"/> Most recent X-rays	<input type="checkbox"/> Most recent EKG	<input type="checkbox"/> Other: _____	

Reason for Record Request: _____ **Approximate Dates:** _____

***HIV, Behavioral Health and Drug & Alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated.**

***Do not release:** (X all that apply) __ Mental Health Information __ Drug & Alcohol Information __ HIV-related information

I understand the following:

- that the health record(s) released by _____ (**Releasing Medical Facility/Doctor**) may possibly be re-disclosed by SHHC and therefore (1) the facility/person and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule
- that this authorization is in effect for a period of 90 days from the date of signature, unless a specific timeframe is documented; however, no time frame specified shall go beyond one year from the signed date
- that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. *See side two of this form for additional patient rights and responsibilities.*
- that I am entitled to a copy of this completed Authorization form if requested

GENERAL AUTHORIZATION *

Patient Signature Date

- A minor may authorize if records are Drug & Alcohol related. If for Behavioral Health, a patient who is 14 or older shall authorize (inpatient records only). A disclosure statement, as required by law, will accompany the records requested.

The above named patient is unable to provide a signature due to:

Legal Representative Signature

Date

Relationship to Patient AND Description of authority to act on behalf of patient: _____

Additional Patient Rights and Responsibilities:

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) SHHC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- SHHC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b) Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plan or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

In order for us to provide you with the best possible care, we may need important information from physicians who are treating you or have previously treated you. Please provide us with the following names/places.

Previous primary care physician: _____

Gynecologist: _____

Ophthalmologist: _____

Endocrinologist: _____

Podiatrist: _____

Other: _____

Where do you get your mammograms?: _____