

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

Please print

The above named person must indicate when this authorization is to expire:

Once information is received In 90 days In one year On this date Specify other _____

The above named authorizes information to be release by: **Behm Family Practice, LLC**

2500 Brooktree Rd., Suite 200, Wexford, PA 15090 Telephone 724-940-0300, Fax 724-940-0301

To: Name of Provider or Facility _____

Address _____

Phone: _____ Fax: _____

To _____

for the purpose of (PROVIDE A DETAILED DESCRIPTION)

I authorize the release of (check all that apply)

Complete medical record

Or more specifically

<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Radiology Studies and Lab Reports
<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Outside consultants and hospitals notes
<input type="checkbox"/> Physician Telephone Notes	<input type="checkbox"/> Medication Records

Information regarding care from the following specified dates

Start Date _____ to End Date _____

- Mental Health Information Initialize _____ Date _____
- Drug and Alcohol Information Initialize _____ Date _____
- HIV Treatment or status Initialize _____ Date _____
- Other please be specific

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. DO NOT RELEASE

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below but may not exceed ONE YEAR from the date of signature. I understand that I have the right to revoke this authorization at any time by _____

Printed name of Patient _____

Date _____

Signature of Patient _____

Signature of Legal Guardian or Authorized Representative and relationship to Patient

- A copy of this release of information as required by law, will accompany all records released.
- My decision to revoke this authorization does not apply to any release of my records that may have occurred prior to the date of my revocation or this authorization.
- The release of records will be for the sole purpose stated on this form. Only those items checked off, listed or specified will be released.
- Behm Family Practice, LLC is not responsible for the re-disclosure or re release of the information released by this authorization by other parties once the information has been delivered to said parties. Note: additional releases or disclosures may not be prohibited by law.
- I am entitled to a copy of this completed Authorization Form.
- You may refuse to sign this authorization form. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist in your health care provider determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, labs results, summaries and consult reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those providers or facilities.

There may be a fee associated with the copying of your medical record. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact the office staff for additional information about applicable copying fees.