

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM AN OUTSIDE FACILITY/PROVIDER

PATIENT NAME _____ DATE OF BIRTH _____
Please print

The above named authorizes information to be release by:

Name of Provider/Facility Name: _____
Address: _____
Phone: _____ Fax: _____

To be released to: **Behm Family Practice, LLC, 2500 Brooktree Rd. Ste 200 Wexford, PA 15090**
Phone 724-940-0300 and Fax 724-940-0301

Records are being requested for the purpose of (provide a detailed description) _____

I authorize the release of (check all that apply)

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Radiology Studies
<input type="checkbox"/> Office Notes Only	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Phone notes	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> EKG Report(s)	<input type="checkbox"/> Outside consultants and hospitals notes
<input type="checkbox"/> Drug and Alcohol Information	<input type="checkbox"/> Mental Health
<input type="checkbox"/> HIV Treatment or status	<input type="checkbox"/> Other please specify

Information regarding care from the following specified dates.

Start Date _____ to End Date _____

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.

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

Once information is received In 90 days In one year Specify other date or occurrence _____

I understand that I have the right to revoke this authorization at any time by writing.

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.

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.

HIV-related, Mental Health and Substance Abuse information contained in the parts of the Complete Medical Record indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE HIV DO NOT RELEASE MENTAL HEALTH RECORDS DO NOT RELEASE substance abuse records
I understand if one of the boxes is checked that medical records can not be sent electronically or in any digital form.

Signature of Patient:

Date: _____

Signature of Guardian or Authorized Representative: (if a minor an authorized representative must sign below):

Relationship to Patient: _____

Date: _____

- 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.

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.

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.