AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME ____ DATE OF BIRTH ______________

Please print

The above named authorizes information to be release by:
Name of Provider or Facility ____
Address ____
Phone: ______________________________ Fax: _____________________________________

Behm Family Practice, LLC, 2500 Brooktree Rd. Ste 200 Wexford, PA 15090 Phone 724-940-0300 and Fax 724-940-0301

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 _______________

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

for the purpose of (provide a detailed description)____

I authorize the release of (check all that apply)

☐ Complete Medical Record	☐ Radiology Studies
☐ Office Notes Only	☐ Lab Reports
☐ Phone notes	☐ Immunization Record
☐ EKG Report(s)	☐ Outside consultants and hospitals notes
☐ Drug and Alcohol Information	☐ Mental Health
☐ HIV Treatment or status	☐ Other please specify

Information regarding care from the following specified dates. Start Date ________________ to End Date _____________

HIV-related 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

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 writing.

Signature of Patient: ____
Date: _________________

Signature of Guardian or Authorized Representative: ____
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 refuel 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.