974 Greentree Road,
Pittsburgh, PA 15220
412-921-7575

Patient Authorization Form

Many of our patients allow family members such as their spouse, significant others, parents, children, or guardians to discuss results of exams, consultations, x-rays, procedures, financial and insurance information. Under the requirements for HIPAA, we are not allowed to discuss this information without your consent. If you wish to grant someone permission you must list them on this form and sign it.

You have the right to revoke this consent, in writing. You have the right to refuse to sign this authorization form. You understand that any action already taken in reliance on this authorization cannot be reversed, and ant revocation will not affect these actions.

1.____ Relationship to Patient: ___________________________

2. _______________________________________ Relationship to Patient: ___________________________

3.____ Relationship to Patient: ___________________________

4.____ Relationship to Patient: ___________________________

5. ____ Relationship to Patient: ___________________________

☐ If you have additional persons you want to list, please list on the back and checkmark the box.

☐ If you wish to not give permission to anyone going forward, please checkmark the box.

Patient's Name: ______________________________________ Date of Birth: _____________________

Signature of Patient or Guardian: _____________________________________ Date: _______________