Steel City Gynecology

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize_____ to release information from the record of:
Name of Facility/Person

_____:_____:_____as described below to
Patient Name Birth Date SSN#

_____ _____ _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

Records are requested for the purpose of: _____

_____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):
   ___ Inpatient; Dates_____ ___ Emergency Dept; Dates_____
   ___ Outpatient; Dates_____ ___ Physician Office / Clinic; Dates_____

2. Specific information to be released (check all that apply):

___ Consultation Reports	___ Medical History & Physical Exam	___ Physician Orders
___ Discharge Summary	___ Progress Notes	___ Operative Report
___ Pathology Report	___ Laboratory Reports / Tests	___ Mammography Report
___ Radiology Report	___ Emergency Dept Report	___ EKG
___ Ultrasound Report	___Other, specify_____	

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated will be released through this authorization unless otherwise indicated. Do not release ___HIV
___ Mental Health ___ Drug & Alcohol

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be re-disclosed and no longer protected by these regulations.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorize above to release the information.

If applicable, specify other expiration date/event here: _____

_____	_____	_____	_____
Date	Signature of Patient (14 years of age or older may authorize Release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)	Date	Signature of parent or legal guardian

_____ _____
Date Witness/Staff Member Signature