NORTH SIDE CHRISTIAN HEALTH CENTER

816 Middle Street
Pittsburgh, PA 15212
Phone: (412) 321-4001
Fax: (412) 321-4063

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize_____, located at
Name of physician or facility

_____
Facility/Physician Street Address City State Zip

Phone: _____ Fax: _____

To release information from the record of: _____
Patient Name

_____ _____
Birth Date SSN/MR#

To be released as indicated below to: _____
Name of Facility/Person

_____
Facility Address

Phone: _____ Fax: _____

Records are requested for the purpose of (Provide a Detailed Description) _____
_____

The records to be released (check all that apply) are (**please include approximate date of the service)**

___Inpatient Records Dates: _____ ____Outpatient Records Dates_____
___Emergency Room Record Dates: _____ ____Physician Office/Clinic Dates: _____

___Medical History & Physical Exam	____Physician Orders	____Psychiatric/Psychological Eval.
___Progress Notes	____Operative Report	____Discharge Summary/Instructions
___Laboratory Reports/Tests	____Pathology Report	____X-Ray Report
___Medication Records	____Consult Report	____Mammography Report
___Immunizations	____Other (specify)_____	

HIV, Behavioral/Mental Health and Drug/Alcohol Information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated below—
Do NOT Release: _____ HIV Information _____Behavioral/Mental Health Information _____Drug/Alcohol Information

I understand the following—

- That my health record(s) will not be released or obtained by North Side Christian Health Center unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information
- That the release of my health record(s) will be for the purpose stated on this form, and only items indicated will be released
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule
- That this Authorization is in effect for a period of 90 days from the date of signature unless a specific time frame is documented; however no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to the entity where the authorization was provided
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization:
- That treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization or if conditioning is permitted by the privacy rule, a statement about the consequences of refusing to sign
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim
- That I am entitled to a copy of this completed Authorization form
- That a photocopy is the same as an original

Initial _____ Date_____ (PLEASE TURN OVER)

GENERAL AUTHORIZATION SIGNATURE*

_____ _____

Patient Signature Date

The above named patient is unable to provide a signature due to:

_____

_____ _____

Legal Representative Signature Date

Relationship to patient and description of authority to act on behalf of patient:

_____

ORAL AUTHORIZATION SIGNATURES

(NOT APPLICABLE TO HIV RELATED INFORMATION)

I witness that the person understood the nature of this release and freely gave his/her oral authorization. (Two witnesses are required.)

_____ _____

Witness #1 Date

_____ _____

Witness #2 Date

*A minor of any age may authorize if related to substance abuse;
A minor who is 14 or older may authorize if related to behavioral health (inpatient records only).

A disclosure statement, as required by law, will accompany the records requested.

Office use only: _____Date copy provided to patient Signature_____