STO-ROX Family Health Center
Part of Sto-Rox Neighborhood Health Council, Inc.

710 Thompson Avenue
Pittsburgh, PA 15136
Phone: (412) 771-6462
Fax: (412) 771-5887

Authorization for Use and Disclosure of Health Information

I hereby authorize _____

(Outside facility's name, address, phone number, and fax number)

to release information from the record of _____

(Patient's name and Date of Birth)

as described below to __Sto-Rox Family Health Center___710 Thompson Avenue Pittsburgh, PA 15136
__Phone: (412) 771-6462 Fax: (412) 771-5887

Records are requested for the purpose of (Please check one): ☐ Continuing Care/Medical Facility

☐ Legal Purpose ☐ Personal Use ☐ Insurance Purpose ☐ Other: _____

1. Type of records to be released with dates of service (check all that apply):

☐ Inpatient/Admission/Emergency Room dates: _____

☐ Outpatient dates: _____

☐ Physician Office/Clinic dates: _____

2. Specify information to be released (check all that apply): ☐ Medical History and Physical Exam

☐ Progress Notes ☐ Medication Records ☐ Physician Orders ☐ Consultation Reports

☐ Discharge Summary ☐ Laboratory Reports/Tests ☐ Radiology (CT, MRI, mammogram, etc.)

☐ EKG Reports ☐ Pathology ☐ Operative Reports ☐ Psychiatric/Psychological Evaluations

☐ Other (specify): _____

Mental health treatment information[i], _HIV/AIDS related information, alcohol or chemical dependency treatment information, and genetic information contained in parts of the record(s) indicated above will be released unless otherwise indicated_. **DO NOT RELEASE (check all that apply):

☐ Mental health treatment information ☐ HIV/AIDS related information

☐ Alcohol and/or drug abuse/chemical dependency treatment information ☐ Genetic information

Acknowledgement of Authorization

This Authorization expires on[ii] (if no date, will automatically expire in 90 days from date of signature):
_____. *See side two of this form for additional patient rights information*.

I have read this release, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Patient Signature: _____ Date: _____

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

Legal Representative Signature: _____ Date: _____

Relationship to patient/description of authority: _____

ORAL AUTHORIZATION

I witness that the person understood the nature of this release and freely gave their oral authorization **(**two witnesses required**)**

Witness #1: _____ Date: _____
Witness #2: _____ Date: _____

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Additional Patient Rights Information

I understand that I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information whose use or disclosure I am hereby authorizing. I acknowledge that information disclosed pursuant to this Authorization may no longer be protected by applicable laws, and could be re-disclosed by the recipient. I understand that I have a right to receive a copy of this Authorization. I may revoke this Authorization at any time, but I must do so in writing and submit it the address below. I understand that my revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. 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.

In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

Patient Signature: _____ Date: _____

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

Legal Representative Signature: _____ Date: _____

Relationship to patient/description of authority: _____

ORAL AUTHORIZATION

I witness that the person understood the nature of this release and freely gave their oral authorization **(**two witnesses required**)**

Witness #1: _____ Date: _____
Witness #2: _____ Date: _____

[i] If mental health information is requested to be disclosed to a third party by the patient, the physician or other provider who is in charge of the patient must approve the disclosure (release). If the disclosure is not approved by the physician/provider, the reasons must be documented in the patient's medical record.
[ii] If the "Authorization for Use or Disclosure of Health Information" is for research purposes, including the creation and maintenance of a research database or repository, the statement "end of research study," or similar language is sufficient.