ALLERGY & CLINICAL IMMUNOLOGY ASSOCIATES

180 Fort Couch Road • Pittsburgh, PA • 15241-1041
FAX: 412 • 833 • 7011
412 • 833 • 8811

1385 Washington Road • Suite 101 • Washington, PA • 15301-9674
FAX: 724 • 228 • 7741
724 • 228 • 7710

A&CI AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of _____
Name of Facility / Person — Patient Name

_____; _____ as described below to _____
Birth Date — SSN/MR# — Name of Facility / Person

_____
Facility Address

Phone: _____ Fax: _____

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION): _____

The records to be released (identify all that apply) are (please include approximate dates of service):

_____ Inpatient Records; Dates: _____; _____ Emergency Room Records; Dates: _____

_____ Outpatient Records; Dates: _____; _____ Physician Office/Clinic; Dates: _____

_____ Medical History & Physical Exam	_____ Progress Notes	_____ Psychiatric/Psychological Eval
_____ Discharge Summary/Instructions	_____ Laboratory Records/Tests	_____ Operative Report
_____ Pathology	_____ Medication Records	_____ Other (specify): _____
_____ Consults	_____ Radiology	_____
_____ Physician Orders	_____ Mammography Report	_____

HIV, Behavioral and Drug and Alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated. Do not release ☐ HIV ☐ Behavioral Health (Psychiatric) ☐ Drug & Alcohol

I understand the following:

- That my health record(s) will not be released or obtained by A&CI unless permission is provided for herein as evidenced by the signature on this authorization for Release of Protected Health Information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those 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 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.

Patient's Signature _____ Date _____

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

Legal Representation _____ _____

Relationship to Patient AND description of authority to act on behalf of patient: _____

ORAL AUTHORIZATION - 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 may authorize it for Drug and Alcohol related; if for Behavioral Health, a patient who is 14 or older shall authorize (inpatient records only)

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

Office Use Only ☐ Copy provided to patient Signature: _____