Today's Date: _____

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ _____ _____ **Date of Birth:** _____
(LAST) (FIRST) (M.I.)

Address:

_____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Use and Disclosure of Protected Health Information

[redacted] is authorized to (circle one): **SEND** *OR* **RECEIVE**

Practice Address: **1050 Bower Hill Rd, POB Suite 304 Pittsburgh, PA 15234**

Phone Number: **412-572-6168** *Fax Number:* **412-563-4517**

_____ is authorized to (circle one): **SEND** *OR* **RECEIVE**
(PERSON(S) / ORGANIZATION(S))

Practice Address: _____
(STREET) (SUITE #) (CITY) (STATE) (ZIP CODE)

Phone Number: _____ *Fax Number:* _____

My health information will be used for the following purpose(s): _____

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient ❑ Outpatient ❑ TCC
❑ Discharge Summary ❑ Imaging Reports ❑ IRU ❑ PT/OT/Speech/Audiology

Treatment Dates: _____

❑ History & Physical ❑ Laboratory Reports ❑ Operative Reports ❑ Emergency Department Record
❑ Consultations ❑ Transfer Abstract ❑ Transfer Abstract ❑ Pathology Reports
❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts
❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services
❑ Specific Exclusions: _____

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ will or ❑ will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires **[insert date or event]** if less than ninety days:_____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **St. Clair Medical Group Pulmonary Medicine, 1050 Bower Hill Rd, POB Suite 304 Pittsburgh, PA 15234**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: _____ **Time:** _____ AM / PM

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

_____ _____/_____/_____
Witness Date

_____ _____/_____/_____
Witness Date