Northside 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 _____
Name of physician or facility

_____
Facility Address – Street Address City State Zip

Phone: _____ Fax: _____

To release information from the record of: _____.
Patient Name

_____ _____
Birth Date SSN/MR#

As described 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 (identify all that apply) are (**please include approximate date of the service)**

_____Inpatient Records: Dates: _____: _____Outpatient Records: Dates _____
_____Emergency Room Records: 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	_____X-Rays
_____Medication Records	_____Consults	_____Mammography Report
_____Immunizations	_____Other (specify):_____	

HIV, Behavioral Health 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 ____Drug and Alcohol

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*

_____ - _____

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 – 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 if 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_____