2540 Monroeville Blvd
Monroeville, PA 15146
412-823-5155
Fax 412-823-8262

Authorization to Release Medical Records

PATIENT INFORMATION:

Name (print) DOB SSN

____ _____________ ______________

INFORMATION TO BE RELEASED FROM:

Name of facility or provider

____

Address

____

INFORMATION TO BE SENT T0:

Name of designated recipient

____

Address City State Zip

____ ____________________ __________ __________

INFORAMTION TO BE RELEASED: (please check one)

I authorize the release of: (check all that apply) ____ Mental Health Information ____Drug and Alcohol Information, contained int the records indicated. Dates: ______________________

Specific information to be release (check all that apply)

___Consults ____Medical history ___Physicians Orders
____Discharge Summary ____Medications Records ____Progress Notes
____Laboratory Reports/Tests ____Psychiatric/Psychological Eval
____Other: ____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless other wise indicated. ____ Do not release

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

______ Attorney _______ Insurance _______ Doctor

MY RIGHTS:

I understand that I can revoke or cancel this authorization at any time by notifying PERSOMA P.C. in writing. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. This authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary and that I am entitled to a copy of the authorization. I can refuse to sign this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules.

____ ____________________
Signature of client or personal representative Date

____ ____________________
Printed name of client or personal representative Description of personal representative's authority

____
If signing in a representative capacity, Witness's signature