Chan Soon-Shiong
Medical Center
at Windber

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name ,			Date of Birth / /
Patient Address	State	Zip Code	Telephone/Cell Phone

REASON: ☐ Treatment (appointment date _____) ☐ Personal ☐ Legal ☐ Insurance ☐ Other (specify): _____

DATES OF TREATMENT: _____

SPECIFY INFORMATION TO BE RELEASED: ☐ photocopies ☐ CD

☐ Lab Reports	☐ Emergency Report	☐ Anesthesia Reports	☐ Operative Reports
☐ Pathology Reports	☐ ED Summary Notes	☐ Discharge Summary	
☐ Radiology, Scans, MRI / MRA	☐ History and Physical	☐ Discharge Instructions & Discharge Medications	
☐ EKGs, Cardiology Reports	☐ Consultation Reports	☐ PT ☐ OT ☐ Speech Therapy ☐ Lymphedema Therapy	
☐ Other (Specify)			

SENSITIVE INFORMATION FROM MY RECORD MAY BE RELEASED UNLESS CHECKED BELOW:

☐ **Do not** release AIDS / HIV / STD information	☐ **Do not** release Mental Health information	☐ **Do not** release Drug / Alcohol / Substance Abuse information

INFORMATION SPECIFIED FOR RELEASE WILL BE RELEASED TO:

Recipient's Name: _____

Recipient's Address: _____

_____

Phone: _____ Fax: _____

I hereby authorize _____ to release protected health information from my medical records as specified above. I understand that these records may include information related to AIDS, HIV, mental health, substance abuse and other sensitive information unless restricted above. I understand that this authorization is effective for a period of **90 days** from the date of signature, unless otherwise specified. No time frame may exceed one year from the date of the signature. Specify expiration date: _____. I understand that I have the right to revoke this authorization at any time by sending a written request to the facility that is responsible for maintaining these records. My decision to revoke this authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the authorization. Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/ person that receives the records may re-disclose the information, therefore (1) WMC and its staff / employees have no responsibility or liability as a result of a redisclosure and (2) such information would no longer be protected by the Privacy Rule. WMC will not condition treatment, payment, enrollment or the eligibility for benefits on the completion of this authorization. A fax copy or a photocopy of this authorization is considered valid.

If not the patient, please check designation below:			
☐ Parent or Legal Guardian	☐ Power of Attorney	☐ Next of Kin of Deceased	☐ Executor of Estate

_____ _____
Date **Signature of Patient or Legal Representative (Specify)**

_____ _____ _____ _____
Date **Signature of Witness** **If Verbal Authorization, Signature of 2nd Witness** **Date**

Rev 5/1/13

CONSREF