Authorization for Release of Protected Health Information

Allegheny General Hospital
320 East North Avenue
Pittsburgh, Pennsylvania 15212-4772

ALLEGHENY GENERAL HOSPITAL
WEST PENN ALLEGHENY HEALTH SYSTEM

Patient Name: _____

Date of Birth: _____

IMPRINT PATIENT'S PLATE HERE

TO: **Allegheny General Hospital (AGH) or** _____

I have been a patient at Allegheny General Hospital, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____ hereby authorize the
(name of patient or legally authorized representative)

AGH Medical Records Department or _____ to release to:

Records Deposition Service, Inc.
(Name of Individual, Facility, Agency, School, or Entity to Receive Health Information)

27355 E. Eleven Mile Road, P.O. Box 5054
(Street Address)

Southfield, MI 48086-5054 P: 248-357-3330 F: 248-357-3337
(City, State) (Zip Code) (Phone No.)

The following information or copies of: (*place a check by types of records desired*)

- ❑ Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, Discharge Summary, ER Report)
- ❑ Discharge Summary ❑ Operative Reports ❑ Consultation ❑ H&P
- ❑ Progress Notes ❑ Radiology (x-ray, CT, MRI, etc.) ❑ Lab Results
- ❑ Emergency Department ❑ Outpatient/Clinic (specify) _____
- ❑ The above information and/or the entire Clinical Record which includes HIV-Related Information.
- ❑ The above information and/or the entire Clinical Record including mental health, drug or alcohol treatment
- ❑ Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment
- ❑ Billing or other business records (*specify*): _____
- ❑ Other (*specify*): _____

from (*date*): _____ to (*date*): _____

at: ❑ AGH ❑ Physician Office _____ (*specify*) ❑ Other Facility _____ (*specify*)

Reason for Request:
- ❑ Continuing treatment ❑ Insurance ❑ Legal
- ❑ Employer ❑ Study/Research ❑ Second Opinion
- ❑ Other _____ ❑ **I do not wish to disclose the reason**

This authorization will expire in six months or: _____
(specify expiration date, event or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the AGH Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

_____ _____
Patient or Representative Signature Date Witness Date
(when required by policy or signing by mark)

If representative, give relationship and authority to act _____

❑ Copy accepted ❑ Copy refused