altheda MEDICAL CENTER

596 Pine Hollow Rd, Kennedy Township, PA 15136
Phone: (412) 875-5275 I **Fax**: (412) 679-7051
altheda.com

HIPAA Authorization for Release of Medical Records

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Address: _____

Recipient of Information:

I, the undersigned patient, hereby authorize the release of my medical records to the following individual (the "Recipient"):

- Full Name of Authorized Individual: _____
- Relationship to Patient: _____
- Phone Number of Recipient: _____
- Address of Recipient: _____

Description of Information to Be Released:

I authorize the release of the following medical records:

- ☐ All medical records
- ☐ Specific treatment records:_____
- ☐ Laboratory reports and test results
- ☐ Medical history
- ☐ Appointment and visit details
- ☐ Other (please specify):_____

Purpose of Disclosure:

The purpose for this release of information is:

- ☐ Personal use
- ☐ Assistance from family member(s)

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☐ Other (please specify): _____

Expiration of Authorization:

This authorization shall remain in effect until the following date: _____ or until it is revoked in writing by the undersigned patient. If no expiration date is provided, this authorization shall remain valid until revoked.

Acknowledgements and Patient's Rights:

By signing this authorization, I acknowledge and understand the following:

1. **Right to Revoke:** I have the right to revoke this authorization at any time, provided such revocation is submitted in writing to the healthcare provider. The revocation will not affect any disclosures made prior to the receipt of the revocation.

2. **Voluntary Disclosure:** I understand that I am not required to sign this authorization. I am voluntarily authorizing the release of my medical information to the designated Recipient.

3. **Non-Conditioned Authorization:** I understand that my healthcare provider will not condition my treatment, payment, or enrollment in a health plan on my signing this authorization.

4. **Further Disclosure:** I understand that the Recipient may disclose the released information to other parties, and that the information may no longer be protected by HIPAA once disclosed to the Recipient.

5. **Right to Access Information:** I understand that I have the right to inspect and obtain a copy of the information that will be disclosed under this authorization, as permitted by law.

Signatures:

By signing below, I consent to the release of the medical information as described above.

- **Signature of Patient (or Legal Guardian):** _____
- **Date:** _____
- **Signature of Legal Guardian (if applicable):** _____
- **Relationship to Patient (if applicable):** _____

This authorization is effective as of the date signed above.