



**AUTHORIZATION FOR
RELEASE OF INFORMATION TO ANOTHER PRACTICE**
(Please print clearly)

Paper copies Note that there will be a **charge** for the cost associated with copying your records if you are not having them sent directly to your new physician or specialist by us. You will be informed of, and billed for, these charges prior to the release of the copies. There will also be a charge for records requested by you that are not required by your new physician or specialist.

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____
Social security number _____ Date of birth _____

I THE UNDERSIGNED, HEREBY AUTHORIZE:

ASSOCIATES IN FAMILY MEDICINE

Sewickley: Michael A. Karp, M.D. Catherine Kananen Roman, D.O. Benjamin K. Boehme, D.O. Hannah Pierskalla, PA-C
412-749-6806
Cranberry Office: Kathleen M. Osten, M.D. Michael A. Karp, M.D. 412-749-6806
Kennedy Office: Brian E. Goldwasser, M.D. 412-771-6003

TO PROVIDE: (provider where records are to be sent)

Facility or Doctor's Name: _____ Phone # _____
Address: Street _____ City _____ State _____ Zip _____

WITH THE FOLLOWING INFORMATION:

Medical Records Summary (includes doctors' notes, hospital records, laboratory and diagnostic tests within past two years, medication list, problem list, most recent EKG, immunization record, and living will/advance directives). If records are being sent for a specialist consultation, the most pertinent records will be sent.
 Other _____ For dates of service: from _____ to _____
PURPOSE OF DISCLOSURE: I am transferring to another practice *Other* _____

Expressed Authorization: *Signature Required*****
I understand that my medical record may contain information related to:
• **Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV**
• **Psychiatric Care**
• **Treatment for alcohol and/or drug abuse.**

I give my consent for release of this information: _____
Signature Date
 I **DO NOT** give consent for release of this information: _____
Signature Date

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

Required: Signature of Patient _____ Date _____
Signature if other than patient (please attach P.O.A documentation) _____ Relationship _____ Date _____
Signature of witness _____ Date _____