Uniquely connected. For life.℠
HERITAGE VALLEY
Health System

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:

HVMG Primary Care West
Dr. Bradley Heiple, D.O. Dr. Melissa Rau, M.D. Dr. Kehkeshan Shah, M.D.
2201 Park Manor Blvd, Pittsburgh, PA 15205
Phone: 724-773-5890 Fax: 724-773-5892

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

Facility/Doctor's Name:_____ Phone:_____ Fax:_____

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