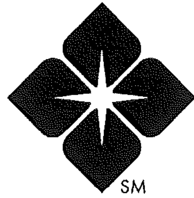

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HERITAGE VALLEY
Health System

Authorization for Release of Protected Medical Information

Date: ________________________

I, ____________________________________ give permission for ______________________
Please Print
Phone number if different than yours: ____________________________

Relationship to Patient : Spouse Parent Son Daughter Caregiver Legal Guardian Significant Other
Other:___________

To receive test results, medical reports, appointments confirmations, and prescriptions or pharmacy information from **Heritage Valley Rheumatology**.

HIV, Behavioral Health and Drug & Alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated.

Do **not** release: _______ HIV _______ Behavioral Health (Psychiatric) _______ Drug & Alcohol

This document will remain in effect until a written notice from the patient revokes this agreement.

Patient Signature :_________________________

Witness:_________________________________