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HERITAGE VALLEY
Health System

Primary Care – Moon Twp.
Authorization for Release of Protected Medical Information

Please list below any family members or friends you permit to receive medical information.

_____

Patient Name (Please PRINT)

_____ ___/____/____

Social Security # **Pt. Birth Date**

I hereby authorize the release of medical information from the patient record to those individuals listed below:

Name of Person or Facility	Phone	Relationship to Patient
Name of Person or Facility	Phone	Relationship to Patient
Name of Person or Facility	Phone	Relationship to Patient
Name of Person or Facility	Phone	Relationship to Patient
Name of Person or Facility	Phone	Relationship to Patient

The information in my Medical Record may be released to the above individuals either by phone or in consultation by any of the providers in the office of Family Practice Associates-Sewickley.

HIV, Behavioral Health and Drug & Alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated.
Dot not release: ☐ HIV ☐ Behavioral Health (Psychiatric) ☐ Drug & Alcohol

I understand that this authorization will stay in effect until revoked by me in writing.

General Authorization

_____ _____

Patient Signature **Date**