



WELCOME TO HVMG WEST ALLEGHNEY HEALTHCARE

It is a pleasure to have you as a new patient in our office. As your healthcare provider, it is our goal to provide you with excellent medical care and to ensure we meet all of your medical needs.

Heritage Valley offers Health Link online where you are able to send medication refill requests, appointment requests, and view test results, along with many other features. You can request an account at www.heritagevalley.org/healthlink. You may also email them at healthlink@hvhs.org and the phone number is 724-773-8344 for any questions.

Please keep in mind that for all routine medical questions, test results, or medication refills, you may call the office between the hours of 8:00AM and 4:00PM Monday through Thursday and 8:00AM – 1:30PM on Friday. **PLEASE ALLOW 48 BUSINESS HOURS FOR ROUTINE MEDICATIONS TO BE CALLED IN TO YOUR PHARMACY.** If you are having a medical emergency after hours, please call our main number 724-773-3001 and you will be connected with our answering service who will contact the doctor on call. If this is a true life threatening medical emergency please dial 911. **PLEASE KEEP IN MIND THAT NO PAIN MEDICATIONS WILL BE CALLED IN BY ANY PHYSICIANS IN THE EVENING OR ON THE WEEKEND.**

Occasionally, you may need a referral to see a specialist or have additional testing done outside the office. If your insurance requires a referral for these services, **PLEASE ALLOW 48-72 BUSINESS HOURS** to obtain such referrals.

Please know it is **YOUR RESPONSIBILITY** to make sure you are presenting your most **CURRENT INSURANCE CARD** at the time of your appointment. If your insurance requires you to select a Primary Care Physician (PCP) please make sure the physician listed on your insurance card is Dr. McCaslin, Dr. Heiple, Dr. Lee, or West Allegheny Healthcare. If you are unsure if your insurance covers our providers please call the member services number on the back of your insurance card to verify we are in network with your plan.

In addition, **co-pays are due at the time of the visit.** Payments may be made by cash, check, debit or credit card. Please arrive 30 minutes prior to your scheduled appointment time to process the new paperwork. We request you please be on time for your appointments as we do our best to stay on schedule. If you arrive **10 minutes** past your scheduled appointment time, you will be asked to reschedule.

If for any reason you are unable to keep your appointment, please contact our office as soon as possible to reschedule. **If your appointment is not cancelled within 24 hours or you do not keep your scheduled appointment you will be charged a \$55. No show fee.**

Per the doctor's request, **PLEASE TURN OFF YOUR CELL PHONE OR PLACE ON SILENT WHILE IN THE OFFICE.**

Once again, we appreciate the opportunity to provide you with medical care and we look forward to a productive doctor/patient relationship for all your healthcare needs.

Sincerely,
Heritage Valley – West Allegheny Healthcare Staff

Heritage Valley Health System



Heritage Valley Medical Group

Heritage Valley Pediatric

Tri State OB/GYN

PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE
 M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # MARITAL STATUS
 () S M W Sep Div

SOCIAL SECURITY # E-MAIL ADDRESS RACE (CIRCLE ONE) ETHNICITY (CIRCLE ONE) OCCUPATION (CIRCLE ONE)
 American/AK Indian; Black/African American Not of Hispanic Origin
 CELL# ALTERNATE# Asian/Pacific Islander; White Hispanic Origin FT PT RET Not Employed
 Unknown/ Decline Unknown/ Decline

EMPLOYER OR NAME OF SCHOOL ADDRESS TELEPHONE # ARE YOU A STUDENT?
 () Yes No Part time Full time

SPOUSE, PARENT OR GUARDIAN INFORMATION (If under 18, name of parent with whom you reside)

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE
 M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # RELATIONSHIP TO PATIENT
 () Spouse Parent Other

SOCIAL SECURITY # EMPLOYER NAME AND ADDRESS EMPLOYER TELEPHONE #
 ()

INSURANCE INFORMATION

PLEASE HAVE CARDS READY FOR STAFF TO COPY

NAME OF PRIMARY INSURANCE CO.

INSURED'S NAME (Subscriber of insurance) SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one			
Self	Spouse	Natural Child with financial responsibility	Step Child
Natural Child without financial responsibility		Adopted Child	
Foster Child			
Significant Other	Life Partner	Grandchild	Organ donor

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF SECONDARY INSURANCE CO.

INSURED'S NAME (Subscriber of insurance) SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one			
Self	Spouse	Natural Child with financial responsibility	Step Child
Natural Child without financial responsibility		Adopted Child	
Foster Child			
Significant Other	Life Partner	Grandchild	Organ donor

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT? Automobile Other _____
 You are required to complete an additional form. Workmen's Comp None

Will patient be best served in a language other than spoken English? : No Yes If yes, please specify _____

EMERGENCY CONTACT

PLEASE NAME A PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP: TELEPHONE # - HOME ()
 TELEPHONE # - WORK ()

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Heritage Valley Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____
 PATIENT OR RESPONSIBLE PARTY ***TURN OVER TO NEXT PAGE***

PATIENT NAME: _____ D.O.B. _____

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

Date Patient Signature HIC #

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

Date Patient Signature HIC #

o **BLUE SHIELD PATIENTS**

We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

o **COMMERCIAL HEALTH INSURANCE PATIENTS**

As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

o **HMO AND PPO PATIENTS**

We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

o **SELF PAY PATIENTS**

Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

Date Patient Signature

Heritage Valley Medical Group
West Allegheny Healthcare Family Practice
300 Penn Lincoln Drive, Imperial, PA 15126
Phone: 724-773-3001 Fax: 724-773-4872

Dr. Todd McCaslin, M.D. Dr. Bradley Heiple, D.O. Dr. Cheng Lee, M.D. Sarah Turner, PA-C

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with the Federal Government privacy rules implemented through the Health Care Port Act 01 1996 (HIPAA), In order for your physician or staff of this practice to discuss your condition with members of your family or other individuals designated by you, we must obtain your WRITTEN AUTHORIZATION prior to doing so. In the event of a critical episode or if you are unable to give your written authorization due to the severity of your medical condition, the law stipulates that rule may be waived.

_____ I **DO NOT** authorize the practice to verbally/written release any or all information concerning my medical care to any individual other than myself.

_____ I **DO** authorize the practice to verbally/written release any or all information concerning my medical care to the following individuals below:

_____	_____	_____
NAME	PHONE #	RELATIONSHIP
_____	_____	_____
NAME	PHONE #	RELATIONSHIP
_____	_____	_____
NAME	PHONE #	RELATIONSHIP

MESSAGES

If you are unable to reach me:

_____ I **DO** give your office permission to leave a detailed message on my voicemail/answering machine.

_____ I **DO NOT** give permission for detailed information to be left on my voicemail/answering machine. Leave a call back number only.

Patient Name: _____ DOB: _____ Phone #: _____

Patient Signature: _____ Date Signed: _____

Heritage Valley Medical Group
West Allegheny Healthcare Family Practice
300 Penn Lincoln Drive, Imperial, PA 15126
Phone: 724-773-3001 Fax: 724-773-4872

Dr. Todd McCaslin, M.D. Dr. Bradley Heiple, D.O. Dr. Cheng Lee, M.D. Sarah Turner, PA-C

**AUTHORIZATION TO RELEASE PRESCRIPTION / SAMPLE AND CONTROLLED SUBSTANCE
PRESCRIPTION**

In accordance with the Federal Government privacy rules implemented through the Health Care Port Act 01 1996 (HIPAA), In order for your physician or staff of this practice to release your medication prescriptions or samples to a family member or other individual designated by you, we must obtain your WRITTEN AUTHORIZATION prior to doing so. In the event of a critical episode or if you are unable to give your written authorization due to the severity of your medical condition, the law stipulates that rule may be waived.

_____ I **DO NOT** authorize the practice to release any of my prescription medications, samples, or written prescriptions to any individual other than myself.

_____ I **DO** authorize the practice to release any of my prescription medications, samples, or written prescriptions for my medical care to the following individuals below:

_____	_____	_____
NAME	PHONE #	RELATIONSHIP
_____	_____	_____
NAME	PHONE #	RELATIONSHIP
_____	_____	_____
NAME	PHONE #	RELATIONSHIP

Patient Name: _____ DOB: _____ Phone #: _____

Patient Signature: _____ Date Signed: _____



Uniquely Connected. For life.™

**HERITAGE VALLEY
HEALTH SYSTEM**

Heritage Valley Health System

Notice of Privacy Practices for Protected Health Information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION. PLEASE REVIEW THIS CAREFULLY.**

Heritage Valley Health System (HVHS) CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are now required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained, electronically transmitted by a covered entity, or information when it takes any other form. PHI is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices. HVHS is required by law to follow the terms of this Notice. HVHS reserves the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, HVHS will make these changes available through distribution of the revised Notice by posting the revised Notice in HVHS facilities and on the HVHS website.

How your Medical Information May Be Used and Disclosed:

- HVHS will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- HVHS may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- During inpatient treatment at a HVHS facility, the hospitals and consulting physicians are considered an Organized Health Care Arrangement (OHCA). This means related health information can be shared for purposes of treatment, payment, or healthcare operations.
- Unless you object, while an inpatient or outpatient of HVHS, and with the exception of behavioral health patients, HVHS:
 - will include general information, including your name, location in the hospital, your condition described in general terms, and your religious affiliation in a list or directory of individuals located in the facility where you are hospitalized. This information, except for the religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
 - disclose to family members, other relatives or close personal friends who are responsible for your care the medical information directly relevant to that person's involvement with your care.
 - use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- HVHS may also:
 - disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
 - use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.

- disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
- disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- disclose your medical information in the course of certain judicial or administrative proceedings.
- disclose your medical information for law enforcement purposes or other specialized government functions.
- disclose your medical information to a coroner, medical examiner, or a funeral director.
- if you are an organ donor, disclose your medical information to an organ donation and procurement organization.
- use or disclose your medical information for certain research purposes.
- use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
- may contact you to raise funds for the hospital.

Your Rights Regarding Your Medical Information:

Your rights related to your medical information are as follows:

- You have the right to request restrictions on certain uses and disclosure of your medical information. HVHS is not required by law to agree to your requested restrictions except when disclosure is to a health plan for services paid exclusively by the patient.
- You have the right to receive communications from HVHS in a confidential manner.
- You have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions. You will be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. HVHS may deny your request for certain specific reasons. If HVHS denies your request a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by HVHS for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- If you do not wish to be contacted for fundraising efforts, you may notify us in one of three ways.
In writing: Heritage Valley Health Systems Foundations, 420 Rouser Road, Suite 102, Moon Township, PA., 15108
By calling: 412-749-7121
Or e-mailing: foundation@hvhs.org
- You have the right to receive a paper copy of HVHS' Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to HVHS and/or to the United States Department of Health and Human Services if you believe HVHS has violated your privacy rights. To complain to HVHS or to request additional information on your privacy rights, please contact HVHS' Privacy Officer by calling (724) 773-3473 or by writing to HVHS Privacy Officer, Heritage Valley Health System, 1000 Dutch Ridge Road, Beaver, PA, 15009. If you choose to file a complaint you will not be retaliated against in any way.
- Per the federal Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification final rule published January 25, 2013, unless a specific exception as identified in 45 CFR 160 or 164 exists, you have a right to be notified of any unauthorized access, use or disclosure of your medical or business information which compromises the security or privacy of such information.

Your Medical Information and Health Information Exchanges (HIE):

HVHS participates in Health Information Exchanges (HIE). Generally, a HIE is an organization that regional hospitals, physicians, and other healthcare providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in the HIE, HVHS may share your health information with other providers or participants of other health information exchanges, by example P3N (Pennsylvania Patient & Provider

Network) and Healthway (a national network that allows providers to exchange information). This health information could include, but is not limited to:

- Test Results. By example, the following tests and results: laboratory including microbiology; pathology; radiology/diagnostic imaging; GI; cardiac; neurological.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary note
- Urgent Care visit progress notes
- Clinical Claims Information

Ancillary healthcare related services providers may include, but are not limited to:

- Organ Procurement
- Diagnostic Testing
- Pharmacies
- Durable Medical Equipment Suppliers
- Home Health Services

All Participating Providers have agreed to a set of standards relating to its access, sharing, use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify your healthcare Provider that you do not wish for your health information to be available through the HIE (“Opt-Out”):

- Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;
- All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;
- Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.
- You may Opt-Out at any time by requesting an Opt-Out form from the registration staff at your point of service or in one of two ways.

In writing: Heritage Valley Health System, Medical Records – Release of Information,
1000 Dutch Ridge Road, Beaver, PA 15009

By emailing: roi@hvhs.org

Please allow (2) business days for the processing of your Opt-Out request.

A list of HIE Participating Providers may be found at: www.heritagevalley.org/hie

This Notice is effective as of April 1, 2003.

Revisions: 8/2008; 6/2012, 9/2013, 12/2015



**HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM
Receipt of Notice of Privacy Practices
Acknowledgement Statement**

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

Patient Name (*please print*)

Patient Signature

Date

**In the event of the patients emergency condition, signature of person receiving
Notice for patient.**

***FOR OFFICE USE ONLY
COMMENTS**

WEST ALLEGHENY HEALTHCARE PATIENT HISTORY FORM FOR ADULTS

Patient Name: _____ Date of Birth: _____ Date: _____

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

Who lives in your household: _____

Have you made a Living Will or put your Health Care Wishes in writing: _____

MEDICAL HISTORY

Please list any chronic conditions you have been or currently are being treated for (Example: High Blood Pressure, Diabetes, Anxiety, Depression):

_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL MEDICATIONS YOU CURRENTLY TAKE (INCLUDE STRENGTH AND FREQUENCY):

<u>Medication</u>	<u>Strength</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies: YES / NO List name of medication and type of allergic reaction:

_____	_____	_____
_____	_____	_____

Do you have a latex allergy: YES / NO

SURGICAL HISTORY

<u>Procedure</u>	<u>Date</u>	<u>Procedure</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____

Date of Birth: _____

Date: _____

Please list all physicians you have seen in the last 5 years:

Physician Name

Type of Doctor/Specialty

Have you had any of the following:

Influenza Vaccine: YES / NO Year: _____

Zostavax (Shingles) Vaccine: YES / NO Year: _____

Tetanus Vaccine: YES / NO Year: _____

Chicken Pox Vaccine: YES / NO Year: _____

Adacel (Tdap) Vaccine: YES / NO Year: _____

Pneumonia Vaccine: YES / NO Year: _____

Medical authorities agree that AIDS can be transmitted by:

- Receiving a blood transfusion involving infected blood.
- Sharing of intravenous drug needles with an infected person.
- Engaging in sexual intercourse with a person who is or has had sexual intercourse with a prostitute, a bisexual, homosexual, IV drug abuser or a hemophiliac.

Do you believe you are at risk for AIDS: YES / NO

Do you desire more information regarding AIDS: YES / NO

Do you desire to be tested for AIDS: YES / NO

WOMEN ONLY

Number of live births: _____

Number of Pregnancies: _____

Date of last Mammogram: _____

Date of last Pap Smear: _____

Thank you for choosing West Allegheny Healthcare services and completing this important health history form. This information will help your doctor provide the best health care for you.

Patient Name: _____

Date of Birth: _____

Date: _____

Please place a check mark if any family members have had any of the following medical problems

	GRAND PARENT	FATHER	MOTHER	SISTER	BROTHER	AUNT	UNCLE	DAUGHTER	SON
DECEASED									
DIABETES									
HYPERTENSION									
HEART DISEASE									
STROKE									
KIDNEY DISEASE									
OBESITY									
GENETIC DISORDER									
ALCOHOLISM									
LIVER DISEASE									
DEPRESSION									
COLON CANCER									
BREAST CANCER									
OTHER CANCER									
OTHER (List):									

Do you currently or have you ever done the following:

Married: _____ Single: _____ Divorced: _____ Widowed: _____

Number of children: _____

Full Time Employment: YES / NO

Full Time Student: YES / NO

Smoke cigarettes/pipe: YES / NO If yes, how many per day: _____

Use smokeless tobacco: YES / NO If yes, how many times per day: _____

Drink Alcohol: YES / NO If yes, how many drinks per day: _____

Use recreational drugs: YES / NO If yes, how many times per week and type: _____

Are there guns in the house: YES / NO

Have smoke detectors in the home: YES / NO

Do you wear a seatbelt regularly: YES / NO



**AUTHORIZATION FOR
RELEASE OF INFORMATION
TO BE SENT TO OUR PRACTICE**
(Please print clearly)

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Social security number _____ Date of birth _____

I THE UNDERSIGNED, HEREBY AUTHORIZE:

Practice or Doctor's Name: _____ Phone # _____

Address: Street _____ City _____ State _____ Zip _____

TO PROVIDE:

HVMG – WEST ALLEGHENY HEALTHCARE

Dr. Todd McCaslin, M.D. Dr. Bradley Heiple, D.O. Dr. Cheng Lee, M.D. Sarah Turner, PA-C
300 Penn Lincoln Drive, Imperial, PA 15126
Phone: 724-773-3001 Fax: 724-773-4872

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 this 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 (use P.O.A. documentation) Relationship Date

Signature of witness Date