



**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:

**Primary Care Associates of Sewickley
Dr Justine Kostrub and Dr MoNika Sauber
100 Hazel Lane, Suite 200
Sewickley PA 15143
Phone: 412-749-6938
Fax: 412-749-6940**

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 _____