Colonnades Family Medicine
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PLEASE PRINT

Patient Name: ____________________________
Social Security Number: ______ - ______ -______
Date of Birth: ____ / ____ / ____

I authorize ____ to release health information to:

Colonnades Family Medicine
Stonewood Commons I
101 Bradford Road
Suite 220
Wexford, PA 15090
(724) 940-5555

INFORMATION TO BE RELEASED

q All Medical Records

q Consultations
q Diagnostic Imaging Reports
q Discharge Summaries
q EKG
q Emergency Medicine Reports
q History & Physical Exams
q Laboratory Reports
q Operative Reports
q Pathology Reports
q Progress Notes
q Radiology Reports

Other ____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

____

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

q I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment(s).
q I specifically authorize the release of information pertaining to mental health diagnosis or treatment(s).
q I specifically authorize the release of HIV/AIDS testing information.
q I specifically authorize the release of genetic testing information.

THE PURPOSE OF THIS RELEASE IS ***(check all that apply)***

- q Continuity of care or discharge planning
- q Billing and payment of bill
- q At the request of the patient/patient representative
- q Other *(state reason)* ____

MY RIGHTS

I may revoke this authorization at any time, provided that I do so in writing and submit it to Colonnades Family Medicine, Stonewood Commons I, 101 Bradford Road, Suite 220, Wexford, PA 15090. The revocation will take effect when Colonnades Family Medicine receives it, except to the extent that Family Colonnades Medicine or others have already relied on it.

I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires *(insert applicable date or event)* ______________
If no date is indicated, this authorization will expire 12 months after the date of signing this form.

SIGNATURE

____ Date: _____________

Signature of Patient or Patient's Legal Representative

____ Time: _____ AM / PM

Printed Name

____

(If signed by someone other than the patient, state your legal relationship to the patient.)

____

Witness or Translator

PLEASE MAIL THIS FORM DIRECTLY TO YOUR CURRENT HEALTHCARE PROVIDER.