East Liberty
Family Health Care Center
A Christian Ministry of Whole Person Healthcare

East Liberty Office
6023 Harvard Street
Pittsburgh, PA 15206
412-661-2802
Fax 412-661-8020

Lincoln-Lemington Office
7157 Mary Peck Bond Pl.
Pittsburgh, PA 15206
412-661-2802
Fax 412-661-8020

Authorization for Release of Medical and/or Dental Records

I authorize the release of my health information, **as described below**

TO:

Provider/Facility _____

Address _____

City _____ State _____ Zip _____

Telephone/Fax _____

FROM:

Provider/Facility: East Liberty Family Health Care Center

Address: 7157 Mary Peck Bond Place

City: Pittsburgh **State**: PA **Zip**: 15206

Telephone: 412-661-2802 / **Fax**: 412-661-8020

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone: _____ Social Security No.: _____

INFORMATION TO BE DISCLOSED:

___ Medical Record ___ Dental Record ___ Other (please specify)_____

Covering the period(s) of healthcare: From: _____(date)** To: _____(date)**

If dates are not provided, healthcare records will be provided for three (3) years prior to the date of the request.

FOR THE PURPOSE OF: (CHECK ALL THAT APPLY):

___ Continuing Care ___ Benefits and payment determination ___ Personal Use ___ Legal Reasons

___ Other (Please specify) _____

I understand that my records may contain sensitive and private health information.

In a primary care setting, reference to infectious disease, drug and alcohol use, and mental health may be part of general documents (such as, but not limited to: History and Physical, Progress notes), which will be released.

Separate documents, pertaining to internal or external specialists' care, regarding the following, **WILL NOT BE RELEASED** unless I, or my legal representative, authorize it, as checked below:

___ HIV _____ Drug/Alcohol _____ Mental Health/Psychiatric Care

I understand that:

- The records released under this authorization may possibly be re-disclosed by the facility that receives them and that, therefore, if the East Liberty Family Health Care Center is releasing records, 1) this office is neither responsible nor liable as a result of such re-disclosure and 2) that such information would no longer be protected by the Privacy Rule.
- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- My decision to revoke this authorization does not apply to any release of my records that may have occurred prior to such date of revocation.
- Unless otherwise revoked, this authorization will expire in ninety (90} days.
- I am entitled to a copy of this completed form.
- I will not be denied treatment by the East Liberty Family Health Care Center if I refuse to sign this form.

_____ _____

Signature of Patient or Legal Representative Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Signature of Witness Date

Office use only: _____Patient received copy of release form _____Patient refused copy of release form

Date Reviewed: _____