SOUTH HILLS DERMATOLOGY, PC
363 Vanadium Road
Suite 101
Pittsburgh, PA 15243
Phone (412) 279-6799 Fax (412) 279-6722

Authorization for Release of Protected Health Information

Patient Name: _____ **Birthdate:** _____

I have been a patient at South Hills Dermatology, PC, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____ hereby authorize SHD to **release to ____** or **obtain from_____**:
(name of patient or legally authorized representative)

_____
(Name of Individual, Facility, Agency, School, or Entity to Receive Health Information)

_____
(Street Address)

_____
(City, State) (Zip Code) (Phone No.)

_____
(Phone No.) (Fax No.)

Information To Be Released:

- ☐ Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's or Reports, Discharge Summary, ER Report)
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation
- ☐ H&P
- ☐ Progress Notes
- ☐ Radiology (x-ray, CT, MRI, etc.)
- ☐ Lab Results
- ☐ Emergency Department
- ☐ The above information and/or the entire Clinical Record which includes HIV-related Information
- ☐ The above information and/or the entire Clinical Record including mental health, drug or alcohol treatment
- ☐ Entire Clinical Record EXCLUDING HIV-related, mental health, drug or alcohol treatment
- ☐ Billing or other business records (specify): _____
- ☐ Other (specify) _____
  From (date): _____ to (date): _____

For The Purpose Of:

- ☐ Employer
- ☐ Continuation of Care
- ☐ Insurance
- ☐ Study/Research
- ☐ Second Opinion
- ☐ Legal
- ☐ Other _____
- ☐ I do not wish to disclose the reason

This authorization will expire in six months or: _____
(specify expiration date, event or time frame of expiration)

I understand that this authorization is subject to revocation at any time, expect to the extent that South Hills Dermatology, PC has already taken action upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization, in writing delivered to South Hills Dermatology, PC Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

_____ _____
Patient or Representative Signature Date Witness Signature Date

If representative, give relationship and authority to act _____