

**I authorize the following facility(s):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Allegheny General Hospital | <input type="checkbox"/> Jefferson Hospital     | <input type="checkbox"/> Physician Office ( <i>provider name</i> ): |
| <input type="checkbox"/> Allegheny Valley Hospital  | <input type="checkbox"/> Saint Vincent Hospital | _____   |
| <input type="checkbox"/> Canonsburg Hospital        | <input type="checkbox"/> West Penn Hospital     | _____   |
| <input type="checkbox"/> Forbes Hospital            | <input type="checkbox"/> Wexford Hospital       | _____   |
| <input type="checkbox"/> Grove City Hospital        | <input type="checkbox"/> Other Facility:        | _____   |
|   | _____   | _____   |

**to release information from the record of:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Patient Phone Number: \_\_\_\_\_

**as described below, the information will be released to:**

Facility/Person to Receive Records \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

I have been a patient at your facility, 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. The facility cannot require me to sign the authorization in order to receive treatment.

**The following information or copies of (place a check by types of records desired):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Consultation Reports            | <input type="checkbox"/> History & Physical Exam  | <input type="checkbox"/> Physician Orders                     |
| <input type="checkbox"/> Discharge Summary               | <input type="checkbox"/> Medication Administration Records  | <input type="checkbox"/> Physician Progress Reports           |
| <input type="checkbox"/> Laboratory Reports/Tests        | <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Psychiatric/Psychological Evaluation |
| <input type="checkbox"/> EKG Report                      | <input type="checkbox"/> Rehabilitation Records   | <input type="checkbox"/> Radiology Report                     |
| <input type="checkbox"/> Nurses Notes                    | <input type="checkbox"/> Pathology Report   |   |
| <input type="checkbox"/> Emergency Department Report     | <input type="checkbox"/> Abstract ( <i>history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports</i> ) |   |
| <input type="checkbox"/> Entire clinical record          | <input type="checkbox"/> Billing or other business records ( <i>specify</i> ): _____                                |   |
| <input type="checkbox"/> Other ( <i>specify</i> ): _____ |   |   |

**HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:**

- |                                       |                              |  |
|---------------------------------------|------------------------------|--|
| <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> HIV | <input type="checkbox"/> Mental Health (Psychiatric) |
|---------------------------------------|------------------------------|--|

(over)...



**Authorization for Release of Protected Health Information**

Patient Identification

**Reason for Request:**

- Continuing treatment
- Legal
- Other: \_\_\_\_\_
- Employer
- Disability
- Insurance
- Study/Research
- I do not wish to disclose the reason

**Dates of Service for record requests:** \_\_\_\_\_

This authorization will expire in six months or: \_\_\_\_\_

**Receiving Format (I would like to receive my records via):**

Email address \_\_\_\_\_

- CD
- USB drive
- MyChart\*
- Paper and Mail
- Paper and pick-up
- Fax

*\*Records are limited to those generated in our Epic system*

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny Health Network has already taken action in reliance 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 and delivered to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**Signature of patient (14 years of age or older may authorize the release of inpatient or outpatient mental health information. A minor may also authorize the release of drug and alcohol treatment information).**

If representative, give relationship and authority to act \_\_\_\_\_

**\*\*If authority to act is a Power of Attorney, supporting documentation must be included with this request.\*\***

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

- Copy accepted
- Copy refused



**Authorization for Release of Protected Health Information**

Patient Identification

# Information Sheet - NOT TO BE SCANNED INTO MEDICAL RECORD

- A service fee for the retrieval of medical records may be applicable.
- Record requests for deceased patients must be accompanied by a copy of the death certificate, short certificate or proof of executor of estate/will.
- For billing information please contact AHN Customer Service: Phone: 844-801-8400 Fax: 1-412-330-5411
- Please contact the radiology department at the specific facility for production of images on a disc.
- Options to submit medical record request:
  - MyChart patient portal-electronic form built within MyChart for submission
  - Mail or fax your request to the hospital or your physician office

All release of information requests must be sent directly to the corresponding facility or physician office. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

## **Allegheny General Hospital**

Attn: Medical Records Dept.  
320 East North Avenue  
Pittsburgh, PA 15212  
Phone: 412-359-4282  
Fax: 412-359-3260

## **Allegheny Valley Hospital**

Attn: Medical Records Dept.  
1301 Carlisle Street  
Natrona Heights, PA 15065  
Phone: 724-226-7095  
Fax: 724-226-7494

## **Canonsburg Hospital**

Attn: Medical Records Dept.  
100 Medical Boulevard  
Canonsburg, PA 15317  
Phone: 724-745-6100, option 2  
Fax: 724-873-5890

## **Forbes Hospital**

Attn: Medical Records Dept.  
2570 Haymaker Road  
Monroeville, PA 15146  
Phone: 412-858-3296  
Fax: 412-858-2341

## **Grove City Hospital**

Attn: Medical Records Dept.  
631 North Broad Street Exit  
Grove City, PA 16127  
Phone: 724-450-7402  
Fax: 724-450-7405

## **Jefferson Hospital**

Attn: Medical Records Dept.  
565 Coal Valley Road  
Jefferson Hills, PA 15025  
Phone: 412-469-5669  
Fax: 412-469-5678

## **Saint Vincent Hospital**

Attn: Medical Records Dept.  
232 West 25th Street  
Erie, PA 16544  
Phone: 814-452-5070  
Fax: 814-454-2348

## **West Penn Hospital**

Attn: Medical Records Dept.  
4800 Friendship Avenue  
Pittsburgh, PA 15224  
Phone: 412-578-1686  
Fax: 412-578-1665

## **Wexford Hospital**

Attn: Medical Records Dept.  
12351 Perry Highway  
Wexford, PA 15090  
Phone: 878-332-4275  
Fax: 878-332-4497

**NOT PART OF THE PERMANENT MEDICAL RECORD  
INFORMATIONAL ONLY**