



St. Clair Hospital
1000 Bower Hill Road
Pittsburgh, PA 15243-1899
Phone: 412-942-4000

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide all information requested may invalidate this Authorization.** I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ Date: _____
(LAST) (FIRST) (M.I.)

Address: _____

Telephone: _____

Date of Birth: _____ Social Security #: _____
(OPTIONAL)

USE AND DISCLOSURE OF HEALTH INFORMATION

Organizations authorized to *use or disclose* the information: _____

Person(s)/Organization(s) authorized to *receive* the information and the address: _____

My health information will be used for the following purpose(s): _____

This Authorization applies to the following information (select all applicable):

All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

Only the following records or types of health information :

In Patient

Out Patient

TCC

IRU

Treatment Dates: _____

Discharge Summary

Imaging Reports

PT/OT/Speech/Audiology

History & Physical

Laboratory Reports

Other

Consultations

Transfer Abstract

Operative Reports

Emergency Department Record

Pathology Reports

Surgical Slides and/or Tissue

[Optional] Specific Exclusions: _____

OVER →

This Authorization specifically includes information relating to (select all applicable):

- Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
- HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, Sexual preference/contacts
- Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services

*If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed.

This information has been disclosed to you from records protected by Pennsylvania Law.

If this Authorization is for Marketing purposes, please note the following:

The organization authorized to use or disclose my protected health information will or will not receive direct or indirect compensation for the use or disclosure of my information.

EXPIRATION

This Authorization expires [insert date or event]if less than ninety days: _____

MY RIGHTS

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: St. Clair Hospital, 1000 Bower Hill Road, Pittsburgh, PA 15243-1899, Attn: Medical Records.

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____