I authorize the following facility(s):

- ❑ Allegheny General Hospital
- ❑ Allegheny Valley Hospital
- ❑ Canonsburg Hospital
- ❑ Forbes Hospital
- ❑ Grove City Hospital
- ❑ Jefferson Hospital
- ❑ Saint Vincent Hospital
- ❑ West Penn Hospital
- ❑ Wexford Hospital
- ❑ Other Facility: _____
- ❑ Physician Office *(provider name)*: _____

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):

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

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:***

- ❑ Drug/Alcohol
- ❑ HIV
- ❑ Mental Health (Psychiatric)

(over)...

Allegheny Health Network

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Authorization for Release of Protected Health Information

Patient Identification

Reason for Request:

❑ Continuing treatment ❑ Employer ❑ Insurance ❑ Study/Research
❑ Legal ❑ Disability ❑ I do not wish to disclose the reason
❑ Other: _____

Dates of Service for record requests: _____

This authorization will expire in six months or: _____

Receiving Format:

❑ Email address _____

❑ CD ❑ USB drive ❑ MyChart ❑ Paper and Mail ❑ Paper and pick-up ❑ Fax

Once information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and no longer protected by federal privacy regulations. With my consent, this authorization may include disclosure of information relating to drug or alcohol abuse (as permitted by 42 CFR Part 2), mental health treatment (except psychotherapy notes) or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 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

Allegheny Health Network

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Authorization for Release of Protected Health Information

Patient Identification

Information Sheet - NOT TO BE SCANNED INTO MEDICAL RECORD

- A service fee for the creation and delivery of your medical records may apply.
- 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: 878-213-3384

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