Cranberry Allergy Asthma and Clinical Immunology

119 VIP Drive, STE 204 Wexford, PA 15090
Phone: (724) 935-1111 ....

Medical Records Release / Authorization for Disclosure of Protected Health Information

For requests for medical records after 8/31/17, you will need to print this form fill it out and mail it to the following address: PO BOX 1513 Cranberry Township, PA 16066*

I authorize **Dr. Albright/ Cranberry Allergy Asthma & Immunology** to release the information as described below from the record of:

Patient Name: ______________________________________ Date of Birth:___ /___ /____

Address: ____

____ Phone: _____________________

- ◻ Summary of Care or Physician Progress Notes for the 2 years prior to the last date seen
- ◻ Laboratory results / records
- ◻ X-ray/Radiology records
- ◻ Allergy test results: ◻ food allergens ◻aero-allergens ◻other __________________________________
- ◻ Pulmonary Function Testing
- ◻ Other ____

Note: HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise specified here: **Do not release:** ◻ **HIV** ◻ **Mental Health** ◻ **Drug & Alcohol**

☐ I would like my records mailed or faxed TO the following address or providers office:

____

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The information may be used/disclosed for each of the following purposes:

- ◻ At my request (only the patient can check this box)
- ◻ For payment/insurance
- ◻ For legal purposes
- ◻ For my health care/ continued medical care
- ◻ For employment purposes
- ◻ Other: _________________________________

This authorization shall expire on: (*please fill in a date that falls 3-6 months after the date of your signature below*) ___ /___ /___ and may not be valid for greater than one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorized above to release the information. My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary (ie. I may refuse to sign it) and that I am not required to sign this form in order to receive treatment. **If I fail to specify an expiration date, this authorization will expire 1 year from the date signed.**

______________________________________ ____________________________________
Signature of patient (or patient's personal representative) Date

______________________________________ ____________________________________
Printed name of patient representative Representative's authority to sign for patient, (i.e parent, guardian, power of attorney for healthcare, executor)