CARDIOVASCULAR DISEASE SPECIALISTS OF PITTSBURGH, PC

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of:

_____ _____ _____ as described below to:
Patient Name | Birth Date | Social Security Number

Cardiovascular Disease Specialists of Pittsburgh, PC
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Phone: 412.924.1100 • Fax: 412.924.1111

Records are requested for the purpose of medical treatment and continuation of care.

1. Type of records to be released and approximated dates of service (check all that apply):
   □ Inpatient, Dates: _____ □ Physician Office, Dates: _____

2. Specific information to be released (check all that apply):

□ Consultation Reports	□ History & Physical Report	□ Chest X-ray Reports
□ Discharge Summary	□ Ultrasound Reports	□ Office Dicatations
□ Laboratory Reports	□ Cardiac Catheterization Reports	□ Treadmill Reports
□ Holter Monitor Reports/Tracings	□ Cardiac Catheterization Films	□ EKG Tracings
□ Emergency Dept Reports	□ Operative Reports	□ Radiology Reports

□ Other: _____

IF INDICATED, PLEASE DO NOT RELEASE INFORMATION REGARDING THE FOLLOWING:
□ HIV □ DRUG/ALCOHOL □ MENTAL HEALTH

_____ _____
Signature of Patient | Date

_____ _____
Signature of Authorized Representative | Date

_____ _____
Authorized Representative's Relationship to Patient | Reason Patient Unable to Sign

ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITES

- 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.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Cardiovascular Disease Specialists of Pittsburgh, PC and its employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- 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.
- 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.
- Cardiovascular Disease Specialists of Pittsburgh, PC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b), Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: 1.Whether the client is or is not in treatment. 2. The prognosis of the client. 3. The nature of the program. 4. A brief description of the progress of the client. 5. A short statement to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- I am entitled to a copy of the completed Authorization form.
- I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here._____