Western PA Women's Healthcare Associates
Drs. Krupski, Ichikawa, Noh, Woo, Carroll, and Smith

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Magee & Wexford: 412-641-6223 (phone) | 412-641-6227 (fax) | 300 Halket St, Suite 5730, Pittsburgh, PA 15213

I. I hereby authorize Western PA Women's Healthcare Associates to release individually identifiable health information from the record of:

_____ _____ _____
(Patient Name) *(Birth Date)* *(Social Security Number)*

_____
(Address) *(City)* *(State)* *(Zip Code)*

_____
*(Phone Number - **required**)*

as described below:

☐ Full Medical Record (All Dates)
☐ Dates: _____

HIV and Mental Health Information contained in the parts of the records indicated above will be released through this authorization *unless otherwise indicated below.*

Do NOT release: ☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

The above information will be called "Authorized Information" throughout the rest of this form.

II. Person(s) or Facility to receive Authorized Information:

_____ _____ _____
(Name) *(Telephone)* *(Fax)*

_____
(Address) *(City)* *(State)* *(Zip Code)*

III. Authorized Information will be used and/or disclosed for the following purposes:

☐ At the request of the individual
☐ Other: _____

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Western PA Women's Healthcare Associates in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Western PA Women's Healthcare Associates by receiving my revocation, or to information that is required by law by my insurance company.
- I understand that I my refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- **This authorization expires at the earlier of six (6) months, OR at the date or event listed as follows:**

_____

_____ _____
(Patient or Representative Signature) *(Date)*

_____ _____
(Print Name) *(Relationship to above Patient)*

PLEASE MAIL RETURN REQUEST TO THE OFFICE WHERE YOU ARE SEEN