# Authorization for Release of Protected Health Information

**Campbell & Philbin Medical Associates**

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**Pittsburgh, PA 15205**
**Tele: (412) 922-2111**
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**Patient Name:** _____

**Date of Birth:** _____

**I have been a patient at Campbell & Philbin Medical Associates, or I am the patient's authorized representative. I understand Campbell & Philbin Medical Associates 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. I, _____ hereby authorize Campbell & Philbin Medical Associates to release to:**

_____
(Name of Individual or entity to receive health information)

_____
(Street Address)

_____,
(City, State) (Zip Code) (Telephone)

**copies of the following:**

_____ **Progress Notes**

_____ **Entire clinical chart including HIV-related information**

_____ **Entire clinical chart including mental health, drug or alcohol treatment**

_____ **Entire clinical chart excluding HIV-related, mental health, drug or alcohol treatment**

_____ **Other (please specify)** _____

**from (date):** _____ **to (date):** _____

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. I understand that I have the right to revoke this authorization at any time by sending a written consent to the entity/person I authorized above to release the information.

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) Campbell & Philbin Medical Associates and its staff/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 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 claim.

Campbell & Philbin Medical Associates cannot require me to sign the Authorization in order to receive treatment.

_____ _____

**Patient or Representative Signature** **Date** **Witness** **Date**

*If representative, give relationship:* _____