Altoona Arthritis & Osteoporosis Center
Altoona Center for Clinical Research
Altoona Specialty Center
Meadowbrook Sleep Center
1125 Old Rte 220 N
Duncansville, PA 16635

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize ______________________________ to release information from the
Name of Facility/Person

Record of: ______________________________ : ____________ : ____________
Patient Name DOB SSN/MR#

As described below to ______________________________ (___) __________
Name of Facility/ Person Phone

____(___)__________ : ______________________________
Fax # Facility/Person Address

Records are requested for the purpose of **(PROVIDE A DETAILED DESCRIPTION)**:

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Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all apply):
   - __ Inpatient dates: ______________
   - __ OutPt dates: ______________
   - ___Emergency Dept: ______________
   - ___ Physician office: dates: __________

2. Specific information to be released (check all that apply):
   - __ Consultation Reports
   - __ Discharge Summary
   - __ Lab Reports/Tests
   - __ Mammography Report
   - __ Emergency Dept: Report
   - __ Other, specify: ______________________________
   - ___ Med Hx and Physical Exam
   - ___ Medication Records
   - ___ Operative Reports
   - ___ Pathology Report
   - ___ EKG Report(s)
   - ___ Physician Order
   - ___ Progress Notes
   - ___ Psychiatric Eval
   - ___ X-ray Reports
   - ___ Discharge Instr.

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 _____ HIV _____ Mental Health _____ Drug & Alcohol

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and many no longer be protected by the federal HIPAA Privacy Rule.

I understand that this Authorization is effective for a period of 1 year from the date of signature, unless otherwise specified below. No time frame may exceed 1 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/person. I authorize above to release the information. If applicable, specify other expiration date/ event here:________________.

Date	Signature of Patient	Date	Signature of Parent Legal Guardian or Authorized Person

Date	Witness/Staff Member Signature

*Authorized Representative's relationship and authority to act on behalf of patient: ____________________

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT applicable to HIV Related information or Drug & Alcohol Information.

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date	Witness # 1	Date	Witness #2