**50 Waterford Pike**
**Brookville, PA 15825**
**Phone: 814-849-6591**
**Fax: 814-849-9942**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| Patient Name | Date of Birth | Phone Number |

**I hereby authorize LaBrasca Plastic Surgery to:** ☐ *RELEASE MY RECORDS TO* or ☐ *REQUEST MY RECORDS* **FROM**:

Name of Facility/Person ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Records are requested for the purpose of:

☐ Continued Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other Specified______________________________

**Dates of Treatment Requested -- MUST BE COMPLETED, IF NOTHING IS MARKED ONLY LAST 2 YEARS WILL BE SENT.**

☐ Most Recent (last 2 years) ☐ All Visits ☐ **Specific Dates:** ____________________

**<u>Information to Release or Request:</u>**

| | | |
|---|---|---|
| ☐ Clinical Progress Notes | ☐ Operative Reports | ☐ Photos |
| ☐ Complete Record | ☐ Testing | ☐ Pathology |
| ☐ Laboratory Reports | ☐ Consults | ☐Other ____________________ |

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☐ **Re-Disclosure of Records from Physicians or Health Care Professionals/Institutions**
**Name or Institution:**

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**Reports of HIV, behavioral health, and drug and alcohol treatment contained in the parts of the record(s) indicated above will be released through this authorization, unless I request otherwise by checking here:** ☐

I understand the following:

- That my health record(s) will not be released or obtained by LaBrasca Plastic Surgery unless permission is provided for herein as evidenced by the signature on this authorization for Release of Protected Health Information (authorization.)
- That the release of my/my child's health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by LaBrasca Plastic Surgery may possibly be re-disclosed by the facility/person that receives the record(s), and therefore (1) LaBrasca Plastic Surgery, and its staff/employees have no responsibility or liability as a result of the re-disclosure. (2) Such information would no longer be protected by the Privacy Rule.
- That this authorization is in effect for the period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this authorization form at any time by sending a written request to the LaBrasca Plastic Surgery, 50 Waterford Pike, Brookville, Pa. 15825. Phone: 814-849-6591. Fax: 814-849-9942.
- That my decision to revoke the authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the authorization.
- That my decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That LaBrasca Plastic Surgery will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization or not.
- That I am entitled to a copy of this completed authorization form.

- I authorize the use of fax for the release or disclosure of the information described above. A photocopy of this consent will have the same effect as the original.

| ______________________________ | ______________________________ | ______________________________ |
| --- | --- | --- |
| Patient Signature | Date | Witness |
| ______________________________ | ______________________________ | ______________________________ |
| Signature of Legal Guardian/Power of Attorney | Date | Witness |

*Patient (is a minor_______ years of age) or (is unable to give consent because)* _______________________________________________