Amelia Arianne Pare', M.D., F.A.C.S., P.C.
123 Hidden Valley Road
McMurray, PA 15317
Phone: 724-941-8838
Fax: 724-941-8878

Authorization for Release of Protected Health Information

Patient Name: ________________________________ Date of Birth ___/___/___

Address: ____
Phone: ____

I have been a patient of Amelia Pare', M.D., or I am the patient's authorized representative. I understand that the facility 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 Amelia Pare', M.D to release my health information to:

____
(Name of individual ,Facility, Agency, School, or entity to receive Health Information)

____
(Address records are to be forwarded to)

____
(City) (State) (Zip) (Phone)

The following information is requested:

______Allergy List
______Hospital documents (H&P, op notes, discharge summary, etc.)
______Lab Results
______Radiology Results (x-ray, CT, MRI, etc.)
______Medication list
______Problem list
______The above information an/or the entire Medical Record that includes HIV-Related information.
______The above information and/or the entire Medical Record including mental health, drug or alcohol treatment.
______Entire Medical Record EXCLUDING HIV-Related, mental health, drug, or alcohol treatment.
______Billing or other business records (specify)______________________________
dates: ______________________________________

Reason for Request:

______Continuing treatment ______Insurance ______Legal _____Employer______Study/Research

______Second Opinion _______Other_______________________________________

I understand that this authorization is subject to revocation at any time, except to extent that this practice has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set for as follows unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may re-disclose information which I have authorized them to receive.

______________________________ ______________________________
Patient or Representative Signature Date Witness Date