Authorization for Release of Protected Health Information

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization/ persons authorized to receive the information is not a health plan or health care provider, the released information may be disclosed and may no longer be protected by federal privacy regulations or state law.

Patient Name:

Patient Address:

Patient Tel. No.:

Patient Date of Birth:

Details of persons/ class of persons/ organization authorized to provide the information (i.e. Name, address, telephone number, etc.):

The Practice of K. Gosai, MD & A.J. Gandhi, MD
1200 McKean Avenue, Suite 107
Charleroi, PA 15022
(724) 489-0866 Phone

Details of persons/ class of persons/ organization authorized to receive the information (i.e. Name, address, telephone number, etc.):

_____
_____
_____
_____

eClinical Works users:
PLEASE SEND RECORDS P2P

Specific Description of information (include date(s)):
❒ Office Notes ❒Labs ❒Hospital ❒Other

_____

Records being sent for:
❒ Continuation of medical care
❒ New PCP

Check if you wish to have any of the following special information disclosed:
❒ Mental Health/ Anxiety Notes
❒ HIV/ AIDS
❒ Drugs/ Alcohol – related Notes

The protected health information will be used and/or disclosed for the following purposes (please list each purpose of the use (s) or disclosure(s) in the space provided):
❒ At the request of the individual (check box if applicable)
❒ Other

I understand that this authorization will expire on _____/_____/_____ (MM/DD/YY) or the date the following event occurs:

_____
(describe the event or write "Not Applicable")

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.

I understand that I may 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 of benefits, except if authorization is needed for receiving research related treatment or for treatment solely for the purpose of creating health information for another party.

(For marketing related authorizations only, if applicable) I understand that the person I am authorizing to use and/or disclose information for marketing purposes may receive either direct or indirect compensation for doing so.

_____
Signature of Patient (or patient's representative)

Date: _____

_____
Printed name of Patient's Representative

_____
Relationship to the Patient