Facility / Provider Name: _____

Address:_____

Phone#: (_____)_____ Fax #: _____

Patient Name: _____

- ❑ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- ❑ Behavioral health services / psychiatric care
- ❑ Treatment for alcohol and/or drug abuse

_____I will pick up the records _____Mail the records _____Fax the records

This information is to be disclosed to:

For the purpose of: _____

I understand that I can revoke this authorization at any time. I understand that I must do so in writing and present the revocation to the Medical Records Coordinator at IUP, Health Service. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire on the following date, event or conditions_____. If I fail to specify expiration, event or condition, this authorization will expire in sixty days.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that if I refuse, the inability to review the information may disrupt continuity of care. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. I understand that records and reports generated by other medical facilities cannot be copied and released to me. To obtain these reports, I must request copies from the originating medical facilities. If I have any questions, I can contact the Medical Records Coordinator at 724-357-2550.

_____ _____

Signature of Patient or Legal Representative **(Date)**

_____ _____

If signed by Legal Representative, Relationship to Patient **Signature of Witness**