HIPAA COMPLIANT

(Health Insurance Portability and Accountability Act)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:
ADDRESS:

MEDICAL RECORD #:
SOCIAL SECURITY #
DATE OF BIRTH:

PHONE #: ( )

Approximate date(s) of treatment: _____

1. I authorize the following health care provider or facility (hospital, physician, etc.) TO DISCLOSE my patient information:

   NAME:

   ADDRESS:

2. I authorize the following person or organization TO RECEIVE my patient information:

   First Review, Inc.
   651 Holiday Drive
   Foster Plaza 5, Suite 300
   Pittsburgh, PA 15220

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

   - ☐ Entire Record
   - ☐ History and Physical
   - ☐ Discharge Summary
   - ☐ Treatment Plans
   - ☐ Radiology and Lab reports
   - ☐ X-Ray/Radiologic films
   - ☐ Operative Report
   - ☐ Immunization Records
   - ☐ Medication Sheets
   - ☐ Psychological Evaluation
   - ☐ Consultation Reports

   OTHER (describe) _____

4. I understand that my records may include information about sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). My records may also contain information about alcohol or drug use, dependence, or treatment or information about behavioral or mental health services.

5. The purpose for the release and disclosure of the above information is indicated below:

   - ☐ Legal/Litigation
   - ☐ Legal/Litigation for Workers' Compensation claim
   - ☐ Insurance
   - ☐ Personal Records
   - ☐ OTHER (MSA)

6. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to the provider listed in PART 1., above. I understand that the revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my health care treatment will not be affected. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations including the Health Insurance Probability and Accountability Act (HIPPA).

7. This authorization will expire one (1) year from the date I sign below. A photocopy of this authorization shall be as valid and effective as the original.

_____ _____
Signature of Patient or legal representative Date

_____
Patient's Name (Print name above)