Dr. Angela M. Stupi, MD

Rachel Pastorek, PA-C - Nicole Haas, PA-C

Caroline O'Neil, PA-C

144 Emeryville Drive, Suite 220

Cranberry Township, PA 16066

Telephone: (724) 935-9355 Fax: (724) 473-5195

Authorization for Release of protected Health Information

Patient Name: ____

Address: ____

DOB: _______________________________________ Social Security Number: ____

I have been a patient at the Physician Practice or 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 ____________________________ to release my protected health information to ____.

The following information or copies of: (place a check by types of records desired)

- ___ Allergy list
- ___ Hospital Documents (H & P, op notes, discharge summary, etc.)
- ___ Lab Results
- ___ Radiology Results (X-ray, CT, MRI, etc.)
- ___ Immunization Records
- ___ Medication list
- ___ Problem list
- ___The above information and/ or the entire Medical Record which 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)**: ____
- ___Other (specify): ____

From (date): ______________________________________ to (date): ____

Reason for Request:

___ Continuing treatment ___ Insurance ___ Legal ___ Employer ___ Study/ Research ___ Second Opinion

___ Other ___________________________________ ___ I do not wish to enclose the reason

This authorization will expire in six months or ______________________________________

I understand that this authorization is subject to revocation at any time, except to the extent that Advanced Rheumatology and Arthritis Wellness Center, PC, or the above named individual, Facility, Agency, School or Entity has already taken action in reliance upon it. A photocopy or facsimile of this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive

____ ____

Patient or Representative Signature Date Witness Date