Authorization for Release of Medical Records and Confidential Information

I authorize the Allegheny County Health Department to release the medical records and/or confidential information from the record of:

Patient Name	Birth Date	SSN/MRN

Release the information to:

Facility/Person to receive records	Phone	Fax/E-mail

Street Address	City	State	Zip code

Please identify the records to be released:

_____

_____

_____

***Note—An individual requesting his or her medical records does not have the right to the following information, including, but not limited to: Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session; and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding) (See 45 C.F.R. § 164.524(a)).**

Date(s) of Service: _____

*I understand that I have the right to revoke this authorization at any time and that I must do so in writing. I understand the revocation does not apply to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in **90 days** from the date of the signature.

Signature of Patient or Personal Representative	Date

Print Name of Patient or Personal Representative	Relationship to Patient

Please mail or fax to:
Allegheny County Health Department
Attn: Legal Section
542 Fourth Avenue
Pittsburgh, PA 15219
Fax: (412) 578-8144