

Dr. Anne Chen MD and Associates

7197 Saltsburg Road
Penn Hills, PA 15235
(412) 704-5095
Fax: (412) 744-4673

Authorization for USE/DISCLOSURE of Protected Health Information

I hereby authorize _____ to release information.
(name of facility or practitioner)

The record of:

Patient Name _____

Date of Birth _____

For the specific purpose of:

Continued Care _____

Personal _____

Release/Disclose information to:

Anne Chen MD and Associates

7197 Saltsburg Rd

Penn Hills, PA 15235

(412) 704-5095

Fax: (412) 744-4673

Please circle type of record: Inpatient Outpatient Emergency Physician Office/Clinic

The information to be released:

History/Physical Exams _____

Medication Sheet _____

Progress Notes/Orders _____

Immunizations _____

It is important that you read and understand the following information that relates to your signing this authorization to use/disclose.

I understand that my authorization is necessary to obtain or release my health information. That I may revoke this authorization at any time, in writing, except to the extent that Dr. Anne Chen may have already relied upon it in making a use or disclosure.

This authorization is limited to the purpose and the person listed above and will be in affect for 90 days after the date of my signature, unless otherwise specified.

Date _____

Signature _____

Date _____

Signature of Witness _____