Dr. Anne Chen MD and Associates

6000 Steubenville Pike, Suite 101
McKees Rocks, PA 15136
(412) 787-7766
Fax: (412) 787-0370

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
6000 Steubenville Pike, Ste 101
McKees Rocks, PA 15136
(412) 787-7766
Fax: (412) 787-0370

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_____**