Southwestern Pennsylvania Human Services, Inc.
•www.sphs.org

Mon Valley Community Health Services, Inc.
2 Eastgate Avenue
Suite 101
Monessen, PA 15062
724-684-8999
Fax: 724-684-7073

Primary Care

MEDICAL RECORDS REQUEST

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEATH INFORMATION

Patient Name:_____ Birth Date:_____

Previous Name:_____ Social Security Number:_____

Address:_____

Home Phone Number:_____ Cell Phone Number:_____

Dear:(Name of provider or organization)_____

The purpose of this letter is to request copies of all my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. This letter serves by my signature that I hereby authorize the medical records to be disclosed and delivered to the designee noted for the purpose of:_____.

Specific records to be released:_____ Copy of Complete Health Record(s)

History and Physical
Discharge Summary
Operative Report
Immunization Records
Other

I was treated in your office:(Location)_____

I am requesting all records related to my treatment dates:_____ to _____

HIV, Mental Health and Drug and Alcohol information contained in the parts of the records will be released through this authorization unless otherwise indicated.

DO NOT Release: _____HIV _____Mental _____Health Drug and Alcohol

I understand that this authorization is effective for a 90 day period from the date of the signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorized above. I understand you may charge a reasonable fee for coping records, but will not charge for time spent locating the records. Please mail the requested records to:

Mon Valley Community Health Services, Inc., Primary Care
2 Eastgate Avenue Suite 101
Monessen, PA 15062-1388

Sincerely,

Patient Signature:_____

Printed Name_____ Date:_____