Robert Rundorff, MD & William Bergin, DO

HIPAA AUTHORIZATION FOR RELEASE **OF INFORMATION**

Patient's Full Name	**XXX-XX-** Patient's Last Four Digits of Social Security Number
Address	Patient's Date of Birth
City, State Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below,

L The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person (or class of persons) may receive disclosure of protected health information about me:

Robert Rundorff, MD & William Bergin, DO
Physical Medicine and Rehabilitation
16 Rose Street Johnstown PA 15905
814-539-0257 Fax: 814-536-0963

3. The specific information that should be disclosed is (please give.dates of service if possible):

SIGN HERE TO DISCLOSE INFORMATION ABOUT ALCOHOL/DRUG ABUSE, HIV/AIDS, OR MENTAL HEALTH
YES, DISCLOSE THIS INFORMATION *

4. l understand that the information used or disclosed may be subject m re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

S. l may re,oke this ,uthorization by notifying in writing of *my* desire to revoke it. However, l understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for

7. This authorization expires on ,20__ , OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING - note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	Date of Individual's Signature	Date of Birth or Social Security Number

OR. if applicable -

Signature of Guardian"' or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only

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