

I authorize the following facility(s):

- ☒ Allegheny General Hospital
☐ Allegheny Valley Hospital
☐ Canonsburg Hospital
☐ Forbes Hospital
☐ Grove City Hospital

- ☐ Jefferson Hospital
☐ Saint Vincent Hospital
☐ West Penn Hospital
☐ Wexford Hospital
☐ Other Facility:

AHN Wexford Radiology

☐ Physician Office (provider name):

to release information from the record of:

Patient Name: Gerald Hogenmiller

Date of Birth: 09/13/1960

Address: 302 Sun Valley Drive
Street

Cranberry TWP.,

PA

16066

City

State

Zip code

Patient Phone Number: (724)-713-2255

as described below, the information will be released to:

Facility/Person to Receive Records Dennis Gabos (Brother) and/or Patient Gerald Hogenmiller

Phone 412-445-5567

Fax

Address: 178 Overbrook Road
Street

Valencia

PA

16059

City

State

Zip code

I have been a patient at your facility, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

The following information or copies of (place a check by types of records desired):

- | | | |
|---|--|--|
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Entire clinical record | <input type="checkbox"/> Abstract (history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Laboratory Reports/Tests | <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Physician Progress Reports |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Psychiatric/Psychological Evaluation |
| <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Rehabilitation Records | <input checked="" type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Pathology Report | |
| <input type="checkbox"/> Billing or other business records (specify): _____ | | |
| <input checked="" type="checkbox"/> Other (specify): <u>Requesting Imaging disc (CD or DVD) of CT scan of chest 12/3/2025, need ASAP for upcoming visit</u> | | |

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

☐ Drug/Alcohol

☐ HIV

☐ Mental Health (Psychiatric)

(over)...



**Authorization for Release
of Protected Health Information**

Patient Identification

Reason for Request:☒ Continuing treatment☐ Employer☐ Insurance☐ Study/Research☐ Legal☐ Disability☐ I do not wish to disclose the reason☐ Other: _____**Dates of Service for record requests:** CT scan of Chest at AHN Wexford 12/3/2025

This authorization will expire in six months or: _____

Receiving Format:☒ Email address dennygabos@gmail.com☒ CD ☐ USB drive ☐ MyChart ☐ Paper and Mail ☐ Paper and pick-up ☐ Fax

Once information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and no longer protected by federal privacy regulations. With my consent, this authorization may include disclosure of information relating to drug or alcohol abuse (as permitted by 42 CFR Part 2), mental health treatment (except psychotherapy notes) or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Only those items checked off or listed will be released.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny Health Network has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and delivered to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature _____ Date _____ Time _____

Signature of patient (14 years of age or older may authorize the release of inpatient or outpatient mental health information. A minor may also authorize the release of drug and alcohol treatment information).

If representative, give relationship and authority to act _____

****If authority to act is a Power of Attorney, supporting documentation must be included with this request.****

Witness Signature _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

☐ Copy accepted ☐ Copy refused

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of Protected Health Information**

Patient Identification

Information Sheet - NOT TO BE SCANNED INTO MEDICAL RECORD

- A service fee for the creation and delivery of your medical records may apply.
- Record requests for deceased patients must be accompanied by a copy of the death certificate, short certificate or proof of executor of estate/will.
- For billing information please contact AHN Customer Service: Phone: 844-801-8400 Fax: 1-412-330-5411
- Please contact the radiology department at the specific facility for production of images on a disc.
- Options to submit medical record request:
 - MyChart patient portal-electronic form built within MyChart for submission
 - Mail or fax your request to the hospital or your physician office

All release of information requests must be sent directly to the corresponding facility or physician office. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

Allegheny General Hospital

Attn: Medical Records Dept.
320 East North Avenue
Pittsburgh, PA 15212
Phone: 412-359-4282
Fax: 412-359-3260

Allegheny Valley Hospital

Attn: Medical Records Dept.
1301 Carlisle Street
Natrona Heights, PA 15065
Phone: 724-226-7095
Fax: 724-226-7494

Canonsburg Hospital

Attn: Medical Records Dept.
100 Medical Boulevard
Canonsburg, PA 15317
Phone: 724-745-6100, option 2
Fax: 724-873-5890

Forbes Hospital

Attn: Medical Records Dept.
2570 Haymaker Road
Monroeville, PA 15146
Phone: 412-858-3296
Fax: 412-858-2341

Grove City Hospital

Attn: Medical Records Dept.
631 North Broad Street Exit
Grove City, PA 16127
Phone: 724-450-7402
Fax: 724-450-7405

Jefferson Hospital

Attn: Medical Records Dept.
565 Coal Valley Road
Jefferson Hills, PA 15025
Phone: 412-469-5669
Fax: 412-469-5678

Saint Vincent Hospital

Attn: Medical Records Dept.
232 West 25th Street
Erie, PA 16544
Phone: 814-452-5070
Fax: 814-454-2348

West Penn Hospital

Attn: Medical Records Dept.
4800 Friendship Avenue
Pittsburgh, PA 15224
Phone: 412-578-1686
Fax: 412-578-1665

Wexford Hospital

Attn: Medical Records Dept.
12351 Perry Highway
Wexford, PA 15090
Phone: 878-332-4275
Fax: 878-332-4497

NOT PART OF THE PERMANENT MEDICAL RECORD INFORMATIONAL ONLY

Phone at AHN Wexford:
878-231-5120 Radiology