

Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS #: _____ Medical Record Number: _____

- 1. I authorize the use or disclosure of the above named individual's health information as described below
- 2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service: _____

- Face Sheet / Registration Sheet / Referral Sheet
- Discharge Summary
- ER Record
- H&P
- Consults
- Progress Notes
- Discharge Instructions
- Lab Results
- Radiology Results
- EKG / Cardiology Testing Results

- Operative Report
- Implant Information
- Pathology Report
- Medication List
- Behavioral Health Information
- Substance Abuse Information
- Human Immunodeficiency Virus (HIV) Information
- Entire Record
- Home Care Records
- OTHER: please specify _____

4. I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).

5. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____

Address: _____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- Sharing with other health care providers as needed
- Other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless I specify differently, this authorization will expire six months from the date signed below: _____

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative _____ Date _____

If signed by legal representative, relationship to patient _____

Signature of witness _____ Date _____

I have been offered a copy of this Authorization Form Accept Refuse

The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his or her consent.

Signature of witness _____ Date _____

Signature of witness _____ Date _____