

SUSQUEHANNA HEALTH SYSTEM

- Divine Providence Hospital
- Muncy Valley Hospital
- Williamsport Hospital
- Skilled Unit

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

I authorize the use/disclosure of information about me as described below:

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_ Medical Record# \_\_\_\_\_

Patient Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Day Phone # \_\_\_\_\_

**PROVIDER/REQUESTOR: I AUTHORIZE SUSQUEHANNA HEALTH SYSTEM TO (RELEASE TO) OR (RECEIVE FROM):**

Provider/Requestor

Name \_\_\_\_\_ Address \_\_\_\_\_

**INFORMATION TO BE DISCLOSED: Dates of Treatment**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> EKG/ECG               | <input type="checkbox"/> Psychological Evaluation  | <input type="checkbox"/> Discharge Instructions/Referral |
| <input type="checkbox"/> Consultations         | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> History & Physical Report | <input type="checkbox"/> Operative Reports               |
| <input type="checkbox"/> Clinic/Progress Notes | <input type="checkbox"/> Laboratory Reports    | <input type="checkbox"/> Pathology Reports         | <input type="checkbox"/> Itemized Billing                |
| <input type="checkbox"/> Radiology Reports     | <input type="checkbox"/> Psychosocial History  | <input type="checkbox"/> Other Specified _____     |  |

**SPECIAL AUTHORIZATION: My evaluation, diagnosis, and/or treatment may be released to the requestor noted above as indicated by my initials next to the information to be released.**

Behavioral Health \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Alcohol &/or drug abuse or dependence \_\_\_\_\_

**REASON FOR THE RELEASE:**

- Insurance
- Continued Care
- Legal
- Other Specified \_\_\_\_\_
- Personal

**REVOCAION:**

I understand that I may revoke this authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

I understand that providing authorization for the requested use or disclosure is not a condition of my treatment, payment, enrollment in a health plan or eligibility for benefits except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that if this authorization for the requested use or disclosure is for Susquehanna Health System marketing purposes, the use or disclosure will result in direct or indirect remuneration from a third party to Susquehanna Health System.

This authorization shall be in force and effect until \_\_\_\_\_. (Note: must specify (a) an expiration date; or (b) an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository).

**AUTHORIZATION:**

I authorize the provider to release the information above to the requestor.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnesses Signature \_\_\_\_\_ Date \_\_\_\_\_

**IF PATIENT IS UNABLE TO CONSENT BECAUSE OF AGE OR PHYSICAL CONDITION, PLEASE COMPLETE ONE OF THE FOLLOWING:**

Patient (is a minor \_\_\_\_\_ years of age) OR (is unable to give consent because \_\_\_\_\_)

Patient Representative's Signature \_\_\_\_\_ 19(Relationship \_\_\_\_\_ Date \_\_\_\_\_