



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 a 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 _____

A copy of this authorization form has been included with the copy of the medical record.

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 _____