



Authorization to Release Medical Records

AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. **Failure to provide all information requested may invalidate this authorization.**

Patient Name (First, Middle, Last):	
Date of Birth:	Social Security number:
Address:	
Telephone Number:	

Purpose of disclosure: (Check one.)

- my personal use: (complete box below)
- continued care
- other use (describe): _____

The **type of information** to be disclosed is as follows: (Check the appropriate boxes.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> All Health Information |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Laboratory Results | |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology Report | |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Pathology Report | |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other (specify) _____ | |

For the following **date(s) of treatment**: (Note: authorization is not valid *prior* to care being rendered.)

From date:	To date:
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Individual(s) or organization(s) authorized to release/disclose the information:			
_____		_____	
(Physician/Facility Name)		(Telephone Number)	

(Street)	(City)	(State)	(Zip)

Individual(s) or organization(s) authorized to receive the information:			
_____		_____	
(Physician/Facility Name)		(Telephone Number)	

(Street)	(City)	(State)	(Zip)



Patient Name: _____

Date of Birth: _____

PATIENT RIGHTS:

I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed it may not be under the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Director of Medical Records or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

Signature of Patient

Date

OR

Signature of Patient's Legal Representative

Date

If signed by Legal Representative, description / relationship to patient:

Note: Proof of legal representation is required.

SENSITIVE INFORMATION:

I understand that my medical record may contain information relating to **AIDS, HIV, psychiatric care, and/or treatment for drug and/or alcohol use.**

I **give consent** for use and disclosure of this type of information:

Signature

Date

I **DO NOT** give consent for use and disclosure of this type of information:

Signature

Date

EXPIRATION:

Authorization **expiration date** or **event**: _____

Note: This authorization is valid for six months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.