Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Authorization For Release of Protected Health Information:

For Access, Use, and Disclosure

For Patient Use: You may retain this portion for your records.

If you need copies of your Heritage Valley medical records, you have several options to choose from.

Visit or create your Health Link Patient Portal account:

With a Health Link Patient Portal account, you can view, send, and print your medical records once they are available. You can create or log into your account by visiting our Health Link Patient Portal page: https://www.heritagevalley.org/patient-visitor-resources/health-link-patient-portal/

For assistance with your Health Link Patient Portal account, please contact: 724-773-8344

Make the request digitally through the Heritage Valley Website:

Visit https://www.heritagevalley.org/patient-visitor-resources/medical-records/ and select the "REQUEST YOUR MEDICAL RECORDS ONLINE HERE" button to request your records online (as shown below).

Complete an authorization form:

Visit https://www.heritagevalley.org/patient-visitor-resources/medical-records/ and select the "Medical Records Release Form" to download the authorization (as shown below).

Complete the form in its entirety, and mail the form to the address below or **fax it to 1-844-372-1011**:

Heritage Valley Health System
Attn: HIM/Medical Records
1000 Dutch Ridge Road
Beaver, PA 15009

OR you may visit one of our hospital locations (Heritage Valley Beaver, Heritage Valley Sewickley, or Heritage Valley Sewickley-Kennedy Campus), obtain the form from the Medical Records department, and drop the completed form in our drop-off box. During regular business hours at our Beaver and Sewickley hospital locations (Monday-Friday, 8:30am-4:00pm), a specialist is available to assist you with completing the authorization and obtaining your records in person.

Cost considerations:

There are no fees associated with releasing medical records to your doctor, healthcare facilities, or retrieving your health information using the Health Link Patient Portal. However, there is a fee for obtaining records for personal use or release to another third party. Fees are determined by state law and the Health Insurance Portability and Accountability Act (HIPAA). Our current fee schedule is located on our website: https://www.heritagevalley.org/patient-visitor-resources/medical-records/

Contact information for release of information services:

Our release of information services are handled by the **MRO Corporation.** If at any point you have questions about requesting information, an existing request, or you need guidance completing the forms, please contact: 724-773-7600.

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Authorization For Release of Protected Health Information:

For Access, Use, and Disclosure

To be completed by the patient or patient representative:
Please PRINT legibly with black, permanent ink. All sections with an asterisk (*) must be completed

* Section 1- I authorize the following facility(s):

☐Heritage Valley **Beaver**
☐Heritage Valley **Sewickley**
☐Heritage Valley Sewickley-**Kennedy** Campus
☐HVMG Physician Office (please specify) _____
☐Other: _____

* Section 2- To release information from the record of:

_____
Patient First and Last Name | Date of Birth | Medical Record Number (if known)

_____
Patient Address (Street, City, State, and Zip Code) | Patient Phone Number

* Section 3- The information will be released to (indicate self, if records are for you, the patient):

_____
Facility/Provider/Person to Receive Records | Phone Number | Fax Number (if known)

_____
Facility/Person's Address (Street, City, State, and Zip Code)

* Section 4- The following information or copies of (please check the records desired):

☐Consultation Reports
☐History & Physical Exam
☐Physician Orders
☐Discharge Summary
☐Medication Records
☐Physician Progress Note
☐Laboratory Report/Tests
☐Operative Report
☐Pathology Report
☐EKG Report
☐Nurses Notes
☐Emergency Department Report
☐Entire Clinical Record
☐Radiology Report
☐Radiology CD/Images
☐Other (please specify):
_____
_____
_____

* Section 5- From the Following Dates of Service:

_____ OR _____
Specific Date of Service | Date Range (From/To)

* Section 6- Reason for Request:

☐Continuing treatment/care
☐Personal use
☐Other: _____

* Section 7- I would like to receive my records via:

☐Paper & Mail ☐ Paper & Pick-up ☐CD & Mail
☐Email: _____ (Please print clearly)
☐Fax: _____ (Please print clearly)

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Authorization For Release of Protected Health Information:

For Access, Use, and Disclosure

*Section 8-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 any time. 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/Time

OR

_____

Signature of Patient's Legal Representative Relationship to Patient Date/Time

(Proof of legal representation is required-Healthcare Power of Attorney, Death/Short Certificate, etc.)

To be completed by staff if signed by legal representative:

_____

Signature of Staff Obtaining Consent Date/Time

☐**Copy of legal representation Obtained**

OR

Verbal Consent (to be completed ONLY if unable to sign/authorize):

We, the undersigned, attest to the fact that the patient named above is **physically** unable to sign this release/consent. The signatures below indicate the patient understood the nature of this release/consent and freely gave his/her verbal consent.

_____

Witness Printed Name Witness Signature Date/Time

_____

Witness Printed Name Witness Signature Date/Time

Section 8a-*SENSITIVE INFORMATION:* I understand that me 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 of Patient Date/Time

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

_____

Signature of Patient Date/Time

Section 9-*Expiration:*

Authorization expiration date or event: _____

****This authorization is valid for six (6) months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.**