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HERITAGE VALLEY
Health System

# AUTHORIZATION FOR RELEASE OF INFORMATION

(Please print clearly)

**PATIENT INFORMATION:**

Name: First_____Middle_____Last_____

Social security number_____Date of birth_____

**I THE UNDERSIGNED, HEREBY AUTHORIZE: (facility that has records)**

Facility name: _____Phone_____

Address: Street_____City_____State_____Zip_____

**TO PROVIDE: (facility where records are to be sent)**

Facility name: _____

Address: Street_____City_____State_____Zip_____

**WITH THE FOLLOWING INFORMATION:**

- ☐ Progress notes
- ☐ Drug\medication Record
- ☐ EKG report
- ☐ Lab results
- ☐ Consultation
- ☐ Accounting of disclosures
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Cardiac Cath Report
- ☐ Pathology Report
- ☐ Special Procedure
- ☐ Operative Report
- ☐ Pulmonary Function
- ☐ Entire Record
- ☐ Other_____

**From the following dates of service/treatment: From:_____ To:_____**

**Purpose of Disclosure:**_____

☐ **Check here to indicate that future healthcare services will not be sought at this location.**

**Expressed Authorization:** ******Signature Required******

***I understand that my medical record may contain information related to:***

- ***Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV***
- ***Psychiatric Care***
- ***Treatment for alcohol and/or drug abuse.***

I give my consent for release of this information: _____
Signature Date

**~or ~**

I DO NOT give consent for release of this information: _____
Signature Date

**Paper copies** (Note that there will be a **charge** for the cost associated with copying your records.)

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information.

⇨_____
Required: Signature of Patient Date

_____
***Signature if other than patient** Relationship Date

_____
Signature of witness Date

*** For signature other than patient, please attach P.O.A. documentation**

☐ Patient given a copy of consent form Records sent: _____By: _____
Date Employee signature

**Patient signature required on back of form.**

**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 control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked 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 Office Manager 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