Health Information Management - Medical Records Request

Heritage Valley Health System has adopted a centralized Release of Information system for patient record requests, in order to ensure the proper release and protection of your records.

The Health Information Management/Release of Information Department is responsible for maintaining the confidentiality, accuracy, integrity and quality of patient information for Heritage Valley Health System. These services include processing requests for patient information.

In order to receive your records, please follow the process outlined below. Please indicate on the Authorization form or letter if you want the records to be emailed (to patients only), faxed or mailed.

NOTE: If you have an appointment scheduled, please write the date by which you need the records on the Authorization form, next to "Purpose of Disclosure," or include in a letter.

Medical records cannot be sent via email to anyone other than the patient. Please include your email address in the section titled: *Individual(s) or organization(s) authorized to receive the information*.

1. Print the request form from the Heritage Valley website at www.heritagevalley.org
   - Click Patient & Visitor Resources
   - Click Health Information Management (Medical Records)
   - Click Medical Records Release Form

2. Write a letter and include:
   - Patient Name & Address
   - Email address (Only for medical records being sent directly to the patient)
   - Patient Date of Birth
   - Phone Number
   - Date of Service for records being requested
   - Types of documents being requested (example: History and Physical, Discharge Summary, Lab Results, Radiology)

   The letter must be signed by the patient or patient's representative. If a representative is signing, please include a copy of the Power of Attorney legal documentation.

To submit your Authorization form or letter, please use one of these three options:

- Mail to: Heritage Valley Sewickley; Attn: Medical Records Department; 720 Blackburn Road; Sewickley, PA 15143
- FAX to: 844-372-1011
- Place in the drop box located outside the Health Information Management/Medical Records Department in each hospital.
- Satellite office staffs: Please FAX the Authorization form for the patient.

If you have questions, please call 724-773-7600. Select *Patient*; *Medical Records*; *Release of Information* to be connected to a staff member during regular business hours.

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HERITAGE VALLEY
Health System

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:
Address:
Telephone Number:

Purpose of disclosure: (Check one.)

☐ my personal use: (complete box below)

☐ continued care

☐ other use (describe): ______________________________

For **personal use only**, check method of access you desire:

☐ **In person** (You must schedule an appointment with the Release of Information Clerk Monday-Friday between 8:00 a.m. and 4:30 p.m.)

☐ **Paper copies** (Note that there will be a charge for the cost associated with copying your records. You will be informed of, and billed for, these charges prior to the release of the copies.)

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

☐ Discharge Summary
☐ History & Physical Examination
☐ Consultation Report
☐ Emergency Department Report
☐ Progress Notes
☐ Operative Report
☐ Laboratory Results
☐ Radiology Report
☐ Pathology Report
☐ Other (specify)
☐ All Health Information

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

From date:	**To date**

Individual(s) or organization(s) authorized **to use or disclose** the information:

☐ **Heritage Valley Beaver** ______________________________

☐ **Heritage Valley Sewickley** ______________________________

☐ **Other:** ______________________________

Individual(s) or organization(s) authorized **to receive** the information:

Name:

Address:

Telephone: **Fax:**

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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.

______________________________ ______________
Signature of Staff Obtaining Consent **Date / Time**

OR

VERBAL CONSENT

We, the undersigned, attest to the fact 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**
Witness Printed Name	**Witness Signature**	**Date**

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.