Penn Highlands Connellsville
Release of Information Authorization Form

I hereby authorize Penn Highlands Connellsville. to release information from the record of

Name of Facility/Person

_____ as described below to

Patient Name Birth Date SSN/MR #

_____ (_____) _____ (_____) _____

Name of Facility/Person Phone Fax

_____

Facility/Person Address

Records are requested for the purpose of: _____

1. Type of records to be released:

☐ Inpatient: Dates _____ ☐ Emergency Dept: Dates _____

☐ Outpatient: Dates _____ ☐ Physician Office/Clinic: Dates _____

2. Information to be disclosed:

____ Consultation Reports	____ Medical History and Physical	____ Physician Orders
____ Discharge Summary	____ Medication Admin Records	____ Progress Notes
____ Laboratory Tests	____ Operative Reports	____ Psychiatric Eval
____ Mammography Report	____ Pathology Report	____ Radiology Reports
____ Emergency Dept Report	____ EKG Reports	____ Discharge Instructions

____ Radiology Films _____

____ Other, Specify: _____

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ____ HIV ____ Mental Health ____ Drug & Alcohol

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. For anyone other than the patient or his or her parent/guardian signing this authorization form, documentation must be on file demonstrating your legal right to sign this authorization form.

_____

Signature of Patient or Legal Representative Date Signature of Witness Date

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV Related Information or Drug and Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization (Two witnesses required)

_____

Date Witness #1 Date Witness #2

Penn Highlands Connellsville
401 East Murphy Avenue
Connellsville, Pennsylvania 15425

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(Label)