AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION –MENTAL HEALTH RECORDS

❑ **PH Brookville** 100 Hospital Road, Brookville, PA 15825; **Phone:814-849-1430** **Fax: 814-849-1429**
❑ **PH Clearfield** 720 Turnpike Avenue, Clearfield, PA 16830; **Phone: 814-768-2370** **Fax: 814-768-2476**
❑ **PH DuBois** 100 Hospital Avenue, DuBois PA 15801; **Phone: 814-375-3485** **Fax: 814-375-3527**
❑ **PH Elk** 763 Johnsonburg Road, St. Marys, PA 15857; **Phone: 814-788-8597** **Fax: 814-788-8053**
❑ **PH Huntingdon** 1225 Warm Springs Ave, Huntingdon, PA 16652; **Phone: 814-643-8608** **Fax: 814-643-7067**
❑ **PH Jefferson Manor** 417 Route 28 Brookville, PA 15825 **Phone: 814-849-8026** **Fax: 814-849-3889**
❑ **PH DuBois Physician Office (Name)__________________Office FAX#: _________** **HIM Phone: 814-375-6596; Fax: 814-375-6388**
❑ **PH Other ______________________________**

Patient Name (Print): ____ MRN: ____________________

Date of Birth: _______________ Date of Request______________________ Phone Number: _________________

Patient Address: ____

I authorize the Hospital listed Above to use or disclose my health information as described below:

☐ **OBTAIN My Record FROM:**		☐ **RELEASE or SEND My Record TO:**		☐ **Pick-up**
Physician/Hospital:		Name		Pick-up Date
FAX#	Phone #	FAX#	Phone #	

MENTAL HEALTH Information FROM (Date/s of Service): ___________________ TO ____________________________

☐ Psychiatric Evaluation	☐ Psychiatric Discharge Summary	☐ Progress Notes	☐ Facesheet
☐ History & Physical	☐ Discharge Instructions	☐ Lab Results	☐ Exchange of school information
☐ Medication Administration Record (MAR)			☐ Other – Specify

I understand that my records are protected under the Health Insurance Portability and Accountability Act, (HIPAA), Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written permission unless otherwise provided for in the regulations.

I understand that any information disclosed in response to this request will NOT include information related to my treatment for AIDS/HIV, and treatment for drug/alcohol, unless I specifically consent to release of this information by Initialling & dating the boxes below:

Int. Date ___ **HIV/AIDS Records** Int. Date _____ **Alcohol &/or Drug Abuse/Dependence Treatment Reason for requesting to use or disclose your Health Record**

☐ Continuation of Medical Care	☐ Changing Physicians	☐ Insurance Eligibility/Benefits
☐Primary Care physician	☐ Legal Investigation/Action	☐ Personal Use
☐Exchange of school and tuition reimbursement	☐ Other	

I understand that I may revoke this authorization verbally or in writing at any time. I understand that if I revoke this authorization, I must contact the Health Information Management Department. I understand that the revocation will not apply to information that was released in response to this authorization. This authorization expires in ninety (90) days, unless otherwise specified.

☐ **Yes**

Signature of Patient or Legal Representative Date ID Verified Employee Witness Signature Date

If signed by person other than the patient, state relationship and authority to do so: ☐ Parent ☐ Minor ☐ Custodial Parent
☐ Legal Guardian ☐ Legal Representative ☐ Deceased Legal Authority ☐ Healthcare Power of Attorney ☐ Incompetent

Yes

Signature of Patient or Legal Representative Date ID Verified Employee Witness Signature Date

↑Sign Here to Pick up Records ↑ ☐ Copy for Patient ☐ Patient Refused Copy

Use Page 2 if Patient/Legal Representative is unable to sign the Authorization

Patient Name: ___________________________ MRN ____________ Date of Birth:___________

IF PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE AND HAS RECORDS THAT ARE BEING RELEASED. PURSUANT TO THE PENNSYLVANIA MENTAL HEALTH PROCEDURES, ACT REGULATIONS, COMPLETE THE FOLLOWING:

We, the undersigned, do verify that the above Authorization was read to (**Patient or Legal Representative)**

____

Patient or Legal Representative Name Relationship Telephone #

and that s/he has indicated understanding the nature of the Authorization and freely gives his/her verbal consent for the release of the information for the reasons noted on Page 1 of this form.

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Employee Witness (Print Name) Signature Position Date and Time

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Employee Witness (Print Name) Signature Position Date and Time

Ref: PA Code 5100.31 – 39
Revised 04/15/14 HIPAA