

# PENN HIGHLANDS HEALTHCARE AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

<input type="checkbox"/> <b>PH DuBois</b> 100 Hospital Avenue DuBois, PA 15801 <b>HIM</b> Phone 814-375-3485 Fax: 814-375-3527	<input type="checkbox"/> <b>PH Brookville</b> 100 Hospital Road Brookville, PA 15825 <b>HIM</b> Phone 814-849-1430 Fax: 814-849-1429	<input type="checkbox"/> <b>PH Clearfield</b> 809 Turnpike Avenue Clearfield, PA 16830 <b>HIM</b> Phone 814-768-2370 Fax: 814-768-2476	<input type="checkbox"/> <b>PH Elk</b> 763 Johnsonburg Road St. Marys, PA 15857 <b>HIM</b> Phone 814-788-8597 Fax: 814-788-8053	<input type="checkbox"/> <b>PH DuBois Physician Office (NAME)</b> <hr/> Office FAX#: _____ <b>HIM</b> Phone: 814-375-6596 Fax: 814-375-6388
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I authorize the use/disclosure of information as described below:

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MRN/Account # \_\_\_\_\_  
 Address: \_\_\_\_\_ Day Phone: \_\_\_\_\_  
 Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I Authorize The Hospital Listed Above To:  **RELEASE MY RECORDS TO:** or  **REQUEST MY RECORDS FROM:**

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_ Fax No. \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_

**INFORMATION TO RELEASE OR TO REQUEST:** Dates of Treatment \_\_\_\_\_

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Cardiopulmonary Services	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Consultations
<input type="checkbox"/> Discharge Instruction/Referral	<input type="checkbox"/> History & Physical Report	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Complete Record
<input type="checkbox"/> Clinical/Progress Notes	<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Imaging Reports / Images
<input type="checkbox"/> Home Health/Hospice	<input type="checkbox"/> Other Specified		

**REASON FOR THE RELEASE:**  Continued Care  Personal  Legal  Insurance  Other Specified \_\_\_\_\_

I understand the following:

- I may refuse to sign this authorization. Refusing to sign this authorization will not affect my treatment, payment of my claim, health insurance enrollment, or eligibility for benefits. I understand that this authorization will expire in ninety (90) days or when the records are released for the requested date. Any requests after this date will need a separate authorization. I may take back (revoke) this authorization, in writing, and understand that some records may have released before the authorization was withdrawn.
- I understand that if my records are released to anyone other than healthcare providers, health plan or government agency/contractor the released information is no longer protected by federal privacy rules.
- I can get a copy of this form after I sign it.
- I am entitled to receive my medical records in electronic format.
- Under the Mental Health Procedures Act., P.L. 92-282, the Pennsylvania, I must complete the mental health authorization form.

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**

<input type="checkbox"/> <b>Give my records to:</b> Pickup Date: _____ Name: _____ (Photo ID required at pick-up)	<input type="checkbox"/> <b>I request my records in Electronic format (If available)</b> <input type="checkbox"/> Compact Disc (CD) <input type="checkbox"/> Email (please provide email below) Email: _____
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_____ Date: _____ ID Verified _____ <small>Patient or Legal Representative Authorized to Sign for patient (proof of legal representation required)</small>	_____ Date: _____ ID Verified _____ <small>Patient, Legal Representative or Person authorized to pick up records</small>
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