PENN HIGHLANDS HEALTHCARE
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

❑ DRMC	❑BROOKVILLE	❑CLEARFIELD	❑ELK REGIONAL	❑ BROOKVILLE Rural Health Clinic (NAME)
100 Hospital Avenue DuBois, PA 15801 HIM Phone 814-375-3485 Fax: 814-375-3527	100 Hospital Road Brookville, PA 15825 HIM Phone 814-849-1430 Fax : 814-849-1429	809 Turnpike Avenue Clearfield, PA 16830 HIM Phone 814-768-2370 Fax : 814-768-2476	763 Johnsonburg Road St. Marys, PA 15857 HIM Phone 814-788-8597 Fax : 814-788-8053	Office FAX#: Office PHONE #:

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 _____

❑ Discharge Summary	❑ Cardiopulmonary Services	❑ Operative Reports	❑ Consultations
❑ Discharge Instruction/Referral	❑ History & Physical Report	❑ Laboratory Reports	❑ Complete Record
❑ Clinical/Progress Notes	❑ Emergency Room Record	❑ Pathology Reports	❑ Imaging Reports / Images
❑ Home Health/Hospice	❑ 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 days (90) 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this authorization, in writing, and understand that some records may have released before the authorization was withdrawn.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

❑ Give my records to: Pickup Date: _____ Name: _____ (Photo ID required at pick-up)	❑I request my records in Electronic format (If available) ❑ Compact Disc (CD) ❑ Email (please provide email below) Email: _____

_____ Date: _____ ID Verified _____
Patient or Legal Representative Authorized to Sign for patient (proof of legal representation required) Employee Initials

_____ Date: _____ ID Verified _____
Patient, Legal Representative or Person authorized to pick up records Employee Initials