General Authorization to Use or Disclose Health Information

Client Name: ____ DOB: ____/___/_____ SS# (last 4 digits): _________ Clint Recd #: _______________

Address: __________________________________ City/State/ZIP: __________________________________ Phone #: _________________________

1. The following individual(s) or organization(s) are authorized to make the disclosure: ____
2. The type of information to be used or disclosed is as follows: Date(s) of Service: ____________________________________

Face Sheet/Registration Sheet

__Progress Notes

__EKG/Cardiology Testing Results

__Discharge Summary

__Operative Report

__Radiology Results:

__ER Record

__Pathology Report

__On CD __On film __On paper

__H&P

__Medication List

__Discharge Instructions

__Consults

__Lab Results

__Home Care Records

Behavioral Health Information ___________Initial

__Entire Record

Substance Abuse Information ___________Initial

OTHER: please specify

Human Immunodeficiency Virus (HIV) Information _______________ Initial

____

Information related to treatment for AIDS/HIV, mental health care, or genetic information will not be disclosed unless specifically checked above.

3. If my authorization includes HIV, Psychiatric/Mental Health, or Drug and Alcohol abuse (substance abuse) information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and Alcohol Abuse Control Act -1972 - Act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures Act 1976, section 5100.3-39).

4. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: ____ Fax: ____

Address: ____

5. This information for which I'm authorizing disclosure will be used for the following purpose:

________ Sharing with other health care providers _______Personal use by patient _________Legal Other (please describe): _____________________

6. This authorization will begin on the date signed below and expire on: ________________________. If no expiration date is specified, this authorization will expire one year from the signature date.

7. I hereby authorize the noted health care facility to use or disclosure the health information as described above. I understand that I may revoke this authorization at any time by sending a written request to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. An oral request for revocation can be accepted in special circumstances.

8. With the exception of AIDS/HIV, Behavioral/Mental Health, and Genetic Information, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. Any information disclosed containing AIDS/ HIV, Behavioral/Mental Health, and Genetic Information is protected under State regulations limiting the recipient's right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____ ______________ Relationship to patient, if signed by Personal Representative

Signature of patient or Personal Representative Date

____ Date________________________

Signature of witness

Verbal Consent: The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his/her consent.

Signature of witnesses: 1. ____ 2. _________________________________ Date: __________

I have been offered a copy of this Authorization Form _____Accept _____Refuse

Patient (or agent/representative) identification verified _____Yes _____No

I would like to receive the records requested in electronic format Yes *(print email below)*

Email (if applicable): ____