

AUTHORIZATION
FOR ACCESS, USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. **Failure to provide all information requested may invalidate this authorization.**

Patient Name (First, Middle, Last):
Date of Birth:
Address:
Telephone Number:

Purpose of disclosure: (Check one.)

- my personal use: (complete box below)
- continued care
- other use (describe): _____

For **personal use only**, check method of access you desire:

- In person** (You must schedule an appointment with the Release of Information Clerk Monday-Friday between 8:00 a.m. and 4:30 p.m.)
- Paper copies** (Note that there will be a charge for the cost associated with copying your records. You will be informed of, and billed for, these charges prior to the release of the copies.)

The **type of information** to be disclosed is as follows: (Check the appropriate boxes.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> All Health Information |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Laboratory Results | |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology Report | |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Pathology Report | |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other (specify) | |

For the following **date(s) of treatment**: (Note: authorization is not valid **prior** to care being rendered.)

From date:	To date
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Individual(s) or organization(s) authorized **to use or disclose** the information:

- Heritage Valley Beaver** _____
- Heritage Valley Sewickley** _____
- Other:** _____

Individual(s) or organization(s) authorized **to receive** the information:

Name:	
Address:	
Telephone:	Fax:

PATIENT RIGHTS:

I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed it may not be under the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Director of Medical Records or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

Signature of Patient _____
Date

OR

Signature of Patient's Legal Representative _____
Date

If signed by Legal Representative, description / relationship to patient:

Note: Proof of legal representation is required.

Signature of Staff Obtaining Consent _____
Date / Time

OR

VERBAL CONSENT

We, the undersigned, attest to the fact the patient named above is physically unable to sign this release/consent. The signatures below indicate the patient understood the nature of this release/consent and freely gave his/her verbal consent.

_____ Witness Printed Name	_____ Witness Signature	_____ Date
_____ Witness Printed Name	_____ Witness Signature	_____ Date

SENSITIVE INFORMATION:

- I understand that my medical record may contain information relating to AIDS, HIV, psychiatric care, and/or treatment for drug and/or alcohol use.
- I give consent for use and disclosure of this type of information:

Signature _____
Date

- I DO NOT give consent for use and disclosure of this type of information:

Signature _____
Date

EXPIRATION:

Authorization expiration date or event: _____

Note: This authorization is valid for six months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.