Authorization for Use or Disclosure of Protected Health Information

Both sides must be completed and signature is REQUIRED.
Any missing information on this form may invalidate this Authorization.

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ Today's Date: _____
(LAST) (FIRST) (M.I.)

Address: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP)

Telephone: _____ Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

Organizations authorized to *disclose* the information: _____

Person(s)/Organization(s) authorized to *receive* the information and contact address/telephone/fax:

_____ _____
(PERSON OR ORGANIZATION) (DELIVERY CONTACT INFORMATION)

_____ _____
(PERSON OR ORGANIZATION) (DELIVERY CONTACT INFORMATION)

_____ _____
(PERSON OR ORGANIZATION) (DELIVERY CONTACT INFORMATION)

What Records Do You Want? (Check appropriate boxes below):

Date(s) of Service: ____/_____/_____ through ____/____/_____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultations
- ☐ Operative ***(Surgical)*** Reports
- ☐ Entire Record
- ☐ ED Report
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Imaging Reports
- ☐ Cath Lab Disc
- ☐ PT/OT/Speech/Audiology
- ☐ UB-04/Itemized Billing
- ☐ Imaging Films

How Would You Like Your Records Delivered?

- ☐ Paper *or* ☐ CD
- ☐ Mail Delivery
- ☐ In-Person Pickup
- ☐ Email (a secure format): _____
- ☐ Other (please specify): _____
- ☐ Fax: _____

Special Instructions: _____

Please be aware that Health Care Facilities are authorized by Pennsylvania State Law to charge for the reproduction of medical records and that charges may be associated with this request.

I understand that this Authorization specifically includes information relating to **(initial ALL)**:

____ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions

____ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and sexual preference/contacts

____ Mental health, psychiatric condition/care, psychological conditions/care, behavioral health services

My health information will be used for the following purpose(s):

❑ Continuity of Care (sharing information between my care providers) ❑ Personal Use

❑ Other: _____

EXPIRATION

This Authorization will expire automatically in ninety (90) days.
If you wish it to expire sooner, insert date or event here:_____

MY RIGHTS

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

SIGNATURE

Date: _____ Time: _____AM/PM

Signature: _____
(Patient or Representative)
If Representative, please state your legal relationship to the patient: _____
Signature of staff obtaining consent: _____ Date/Time: _____AM/PM

Verbal Consent (for persons physically unable to sign)

I witness that the patient understood the nature of this release and freely gave their verbal authorization.

_____	_____	_____	_____
Date	**Witness #1**	**Date**	**Witness #2**