AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Conemaugh Memorial Medical Center Conemaugh Physician Group Conemaugh Miners Medical Center

Conemaugh Meyersdale Medical Center Conemaugh Nason Medical Center

ROI

Patient Name _____ **Date of Birth** _____ **Patient Phone #** _____

Patient Address _____

Reason for release: ( ) Continuity of care ( ) Insurance ( ) Legal ( ) Self ( ) Other (specify) _____

1. I hereby authorize Conemaugh Health System, or any of its affiliates to: ( ) obtain information from **OR** ( ) release information to:

Name/Facility _____ / Telephone Number

Address _____ / Fax Number

Treatment Dates: Inpatient ____/____ From To **Ambulatory** ____/____ From To **Emergency** ____/____ From To **Outpatient** ____/____ From To

2. **PLEASE SELECT WHAT DOCUMENTS YOU WANT TO BE INCLUDED IN THIS RELEASE REQUEST:**

____ History and Physical Exam
____ SPU/ASU Treatment Record
____ Physician Notes
____ Emergency Room Report
____ Operative Report(s)
____ Physician's Orders
____ Laboratory Data
____ Radiology Report/Films/CD
____ Nursing Notes
____ Pathology Report
____ Discharge Summary
____ Consultation(s)
____ EKG/Cardiology Report
____ Clinic Notes - list Clinic Name: _____
____ Medication Sheets

Other, Specify _____

3. I authorize the inclusion of the following type of information, which I understand is specifically protected by federal/state statues:

☐ HIV/AIDS information ☐ Alcohol/drug treatment ☐ Mental health treatment

4. **Revocation Process:** I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this authorization. I understand that the revocation of this authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This authorization will expire six months from the date of my signature .
5. **Right to Copy/Voluntary Disclosure:** I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary. I acknowledge that my records may be redisclosed in accordance with federal or state law.
6. **Health Plan/Insurance Issuers-Conditions:** I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.
7. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization may deny the release of protected health information if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested or (4) if this authorization has expired.
8. **Fees:** It is understood and agreed that the individual presenting this authorization for release of medical records will pay Pennsylvania regulated fees charged for this service as required by law, as posted by the Department of Health at https://www.health.pa.gov/topics/administrative/pages/medical-record-fees.aspx

By signing below I represent that I authorize release of otherwise protected health care information to the person or entity identified above.

Patient's Signature (Photo ID required) / Date/Time _____ / _____

Signature of staff who obtained the consent/ Date/Time _____ / _____

Signature Authorized Individual* / Date /Time _____ / _____

Relationship to Patient _____

NOTICE TO PARTY RECEIVING INFO: This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by prior written consent of the person to whom it pertains.

VERBAL CONSENT

If unable to sign this authorization, verbal consent to the above authorization and verbal statement of understanding of this authorization has been witnessed by two individuals whose signatures appear below.

Witness: _____ Date/Time: _____ Witness: _____ Date/Time: _____

***Attach document to prove your authority to act on behalf of patient**

Patient Information

Health Information Services
1086 Franklin Street
PHONE 814-534-9430 FAX 814-534-3249

Conemaugh Health System

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