AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Please read and complete all items

Patient Name: _____ Date of Birth_____
(First) (Middle) (Last)

Address: _____
(Street) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____

I authorize: ☐ **KEYSTONE HEALTH (network) or: (Select a location)**

☐ Keystone Family Medicine ☐ Keystone Internal Medicine ☐ Keystone Pediatrics ☐ Keystone Women's Care
☐ Keystone Behavioral Health ☐ Keystone Urgent Care ☐ Keystone Dental ☐ Keystone Chiropractic
☐ Keystone Foot and Ankle ☐ Keystone Pediatric Developmental Center (OT/Audiology& Speech)
☐ Keystone Community Health Services (Infectious Disease & Community Outreach Programs)

to:

☐ **obtain from**: _____ ☐ **disclose to**: _____
(Organization) (Organization)

Address_____ Address_____

_____ _____

_____ _____
(Phone) (Fax) (Phone) (Fax)

the following information from my medical record (*please specify date range*)

Dates of service (from) _____ (to) _____

☐ **Complete Medical Record** (Physician office notes, outpatient consult reports, diagnostic reports, laboratory results and hospital reports from all locations listed above, for the period of the last 3 years, unless specified above)

☐ **Complete Dental Record** (Dentist office notes, consult reports and x-ray images for the period of the last 3 years, unless specified above)

Or: Select items-

☐ Diagnostic Test Results (please specify) _____
☐ Itemized Billing Statement ☐ Physician Office Notes ☐ Immunization Record
☐ Outpatient Consult Notes ☐ Hospitalization Reports ☐ Mental Health Records
☐ Other (please specify): _____

For the purpose of:

☐ Transfer of Care ☐ Continuity of Care ☐ Insurance Reasons ☐ Verbal Exchange ☐ Treatment
☐ Relocation/Moved ☐ Legal Investigation ☐ School Exchange ☐ Unhappy with Care
☐ Other_____

How information is to be provided:

☐ Paper Copy ☐ Electronic Copy (Thumb Drive/CD)

Method of Delivery

☐ US Mail ☐ Fax ☐ Pick up in Office

- I understand that fees may be charged for paper copies in accordance with the limitation on fees charged to patients and their personal representatives under HIPAA and the limitations on fees for others under PA Law. {55 Pa Code §5100.34}. A flat fee of $6.50 per electronic format request as permitted by HITECH ACT.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral health services and treatment of alcohol or drug abuse. **State and Federal Law protect the following information.**

I authorize the release of the following information:

Drug and Alcohol Treatment	☐ Yes ☐ No	Dates: _____
Behavioral Health Treatment	☐ Yes ☐ No	Dates: _____
HIV/AIDS	☐ Yes ☐ No	Dates: _____
Sexual Abuse/Assault Counseling Treatment	☐ Yes ☐ No	Dates:_____
Reproductive Health/STD Treatment	☐ Yes ☐ No	Dates: _____

- I understand that this authorization is voluntary and I may refuse to sign and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.
- I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Keystone Health Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand this authorization will expire: one (1) year from the date of this form unless otherwise specified or earlier terminated in writing by patient.   Specify Date (less than one year) ____/_____/______.
- I understand this authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.
- I understand that if I am a minor, under the age of 18, and have consented to health services involving, *reproductive health /STD testing, drug and alcohol or behavioral health treatment,* that my signature is required for any disclose of such Information.

My signature acknowledges that my representative or I have been offered and/or received a copy of this document that I have read and understand the content of this authorization, and voluntarily consent to the release of information.

____ ______________________
Signature of Patient or Personal Representative Date

____
Personal Representative/ Relationship

<u>If patient is unable to consent or is a minor, complete the following:</u>
If signed by a person other than the patient, select the relationship. ***Legal documentation may be required.***

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Custodial Parent ☐ POA ☐ Personal Representative
☐ Executor of Estate

<u>VERBAL AUTHORIZATION:</u> This portion to be completed when a patient is unable to give written consent.
We, the undersigned, do verify that the above authorization has been read to the client and that they have indicated they understand the nature of the authorization and freely give their verbal consent for the release of the above information.

____ ______________________
Signature of Responsible Person (witness) Date

____ ______________________
Signature of Responsible Person (witness) Date

PLEASE MAIL OR FAX THIS FORM AND RECORDS TO:

Keystone Health-Attn HIM Department
Attn: HIM Department
111 Chambers Hill Drive, Suite 200
Chambersburg, PA 17201
Phone Number: (717)709-7960
Fax Number: (717) 217-1937
Email: khc-him@keystonehealth.org

--DISPOSITION OF RELEASE ----- OFFICE USE ONLY --

Faxed: _____________ Mailed: _____________ Patient pick-up:_____________ Staff Initials _____________ Date___________________