AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*****PLEASE READ AND COMPLETE ALL ITEMS*****

Patient Name: _____Allias/Maiden Name:_____

Date of Birth: _____ Last 4 of Social Security Number: _____

Address:_____

City:_____ State: _____Zip Code:_____

Home Phone:_____ Cell Phone:_____

I authorize the use/disclosure of health information about me as described below:

To obtain from: _____
(Practice/Service/Organization)

Address: _____

_____

Fax :_____Phone:_____

Disclose To:_____
(Practice/Service/Organization)

Address: _____

_____

Fax: _____ Phone: _____

Description of Information to be Disclosed:

Dates of Treatment: From: _____ To: _____
(Please Specify the Date of Service)

❑ **Abstract of Medical Records for the date specified above:** *(specify date range above)*
Physician, Psychiatric, Therapy Progress Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, Other diagnostic studies, Discharge Summary, Emergency Department Reports, and Immunization record.

OR:

❑ Laboratory Results ❑ Billing Statement ❑ Immunization Record ❑ Physician Progress Notes
❑ Consult Notes ❑ Imaging ❑ Hospital Reports
❑ Medication/Problem List ❑ Dental Records_____
❑ Other _____

Outpatient Behavioral Health/Substance Abuse Treatment Reports:

❑ Therapy Progress Notes ❑ Psychiatric Progress Notes ❑ Psychiatric Evaluation ❑ Substance Abuse Treatment Notes

For the purpose of:

❑ Continuity of Care ❑ Transfer of Care ❑ Insurance Benefits ❑ Legal Investigation ❑ Billing Inquiries
❑ School Exchange ❑ Relocation ❑ Employer ❑ Verbal Communication
❑ Other (please specify): _____

How information is to be provided: Method of Delivery ❑Paper Copy ❑ Electronic Copy (Thumb Drive/CD) ❑ Fax
❑Email:_____

SPECIAL AUTHORIZATION: I understand that my medical records may contain alcohol/drug abuse, Genetic information, Human Immune virus/Acquired Immune Deficiency Syndrome related and /or mental health, physical abuse information.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ❑ AIDS/HIV Related Information and/or Testing; ❑ Behavioral/Mental Health Services; ❑ Drug and/or Alcohol Treatment ❑ Sexual abuse, child abuse, elder abuse. ❑ Genetic Information*(including genetic test results)*

_____ **Patient Initials** (required)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- 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, drug and alcohol, or mental health treatment, that my signature is required for any disclosure of such information.

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

_____ _____

Signature of Patient (A minor's signature (ages 14-17) is required for the following records: HIV related information, sexually related treatment, mental health care or substance abuse treatment. Date

_____ _____

Signature of Parent, Legal Guardian, or authorized representative Date

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

<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

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

_____ _____

Signature of Witness Date

_____ _____

Signature of Witness Date

Forward To: Keystone Health
HIM- Release of Information 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

3/11/21 ksw

**********Office Use Only**********

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____