# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*F761*

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

**Patient Address** _____

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

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

_____ / _____
Name/Facility Telephone Number

_____ / _____
Address Fax Number

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

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

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

Other, Specify _____

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment, except as identified and specified immediately below:
**ITEMS OR DATES TO EXCLUDE:** _____ **Initial Here** _____

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 in Health Information Services (See fee schedule at http://www.portal.health.state.pa.us)

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.

I _____, am unable to sign this authorization. My verbal consent to the above authorization and my 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 Memorial Medical Center
Johnstown, PA 15905 814-534-9000

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