AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

-Place Patient Label Here-

PATIENT INFORMATION: (Please Print – Must be completed in ink)

Patient Name	Maiden Name	Date of Birth		Social Security Number
Address	City	State	Zip Code	Phone Number

RELEASE FROM:

I authorize release of my medical records from:____

RELEASE TO: (Name of Physician/Facility/Person receiving information)

Please send my records to:

Physician/Facility/Person				Phone Number
Address	City	State	Zip Code	Fax Number

RELEASE INFORMATION

Reason:

- ☐ Insurance
- ☐ Specialist Consult
- ☐ Transfer of Care
- ☐ Legal
- ☐ Lay Caregiver
- ☐ Moving Out of Area
- ☐ Personal File/Other ______________________

Please Release the following: (Check all that apply)

- ☐ Complete Medical Record — Admit Date:__________________________
- ☐ Test Results Only — Discharge Date:__________________________
- ☐ Other Records (Please specify) ____

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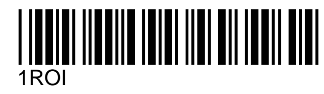
PATIENT AUTHORIZATION AND RIGHTS:

By signing this authorization I understand the following:

1. **I understand that my consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.**
2. This authorization expires in 90 days from the date of my signature, unless authorization has been previously revoked.
3. I have the right to revoke this authorization form at any time by sending a written request to the HIM Department at Somerset Hospital.
4. If I decide to revoke this Authorization, this does not apply to record(s) already released prior to revocation.
5. Any decision to revoke this Authorization may result in non-payment by an insurance company, and I may then be liable for payment of this claim.
6. My health record(s) will not be released or obtained by Somerset Hospital unless permission is provided for as evidenced by the signature on this Authorization for Release of Protected Health Information.
7. The release of my health record(s) will be for the purpose stated above and only those items above will be released.
8. Health records released by the facility/person authorized above may possibly be disclosed by the facility/person that receives the record(s), if this occurs our staff/employees have no responsibility or liability as a result of the re-disclosure and this information would no longer be protected by the Privacy Rule.

Patient's Signature	Date	
If the patient is a minor, subject to a guardianship or is deceased, I have signed my name below on behalf of the patient and myself: (Indicate relationship)	Date	
Witnessed by (Staff Signature)	Date	

Please be aware that health care facilities are authorized by Pennsylvania State Law to charge for the search and reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will then be sent upon receipt of payment.



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Original Unknown
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