AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*** * * Please read and complete all items * * ***

Patient Name: ______________________________ **Alias/Maiden Name:** ____________________

Date of Birth: ____________ **Last 4 of Social Security Number:** __________ **Phone Number:** ______________

Address: ____

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

☐ to obtain from: ______________________
(What Organization)

Address: ______________________

____

☐ disclose to: ______________________
(Release to What Organization / To whom)

Address: ______________________

____

The following information from my medical record (***Please specify visit dates***) ***From*** ____________ ***To*** ____________

☐ **Complete Medical Record or specific information as selected below:**

☐ **Abstract of Hospital Medical Record** (History & Physical, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory, Imaging Reports, and all diagnostic studies)

☐ **Individual Results Listed Above (please specify):** ______________________
☐ **Physician Office Notes**
☐ **Imaging Films and/or CDs**
☐ **Billing Statements**
☐ **Grant WellSpan Employee access to my entire Electronic Medical Record.** This **DOES NOT** authorize the WellSpan Employee to disclose, modify, or provide any official medical advice on my behalf.

☐ **Other** (Please Specify):______________________

Outpatient Behavioral Health Reports:

☐ **Medication Check Visits** ☐ **Psychiatric Evaluation** ☐ **Psychological Evaluation**
☐ **Mental Health Progress Notes**

☐ **Other** (Please Specify):______________________

For the purpose of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Eligibility / Benefits**
☐ **Changing Physicians** ☐ **Legal Investigation** ☐ **Billing Inquiries**
☐ **Establish Payment Plan**

☐ **Other** (Please Specify):______________________

- 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 or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No
HIV Testing and Results ☐ Yes ☐ No
Behavioral or Mental Health Records ☐ Yes ☐ No

- I understand there may be charges for the copies of my health record in accordance with Pennsylvania Department of Health Regulations or the Health Insurance Portability and Accountability Act.
- I understand that I may refuse to sign this authorization and that 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 the Release of Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- **This authorization expires in 180 days, unless otherwise specified as follows:** ______________________________
  (Not to exceed 1 year from date of signature)

______________________________ ______________________________
Signature of Patient/Responsible Party Date

____
Print Name of Patient/Responsible Party

______________________________ ______________________________
Signature of Witness Date

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

If signed by a person other than the patient select relationship. Legal Documentation may be required.

Patient is ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Custodial Parent ☐ Authorized Legal Representative
☐ Power of Attorney for Healthcare

Note: My signature acknowledges that I or my representative received a copy of this document. 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.

☐ Patient Offered Copy and Received ☐ Patient Offered Copy and Declined

VERBAL AUTHORIZATION: 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 he/she has indicated understanding the nature of the Authorization and freely gives his/her verbal consent for the release of the above information.

______________________________ ______________________________
Responsible Person's Signature Date

______________________________ ______________________________
Responsible Person's Signature Date

PLEASE MAIL OR FAX THIS FORM TO:

WellSpan Health
Health Information Management – Release of Information
912 South George Street
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119

*** * * Copies of medical records should be sent directly to the requesting practice or physician * * ***

Requests for health information and invoices are processed by