

Patient Name: _____ Medical Record/Social Security #: _____

Date of Birth: _____ Phone #: _____

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individual or organization is authorized to make the use or disclosure:**

Address: _____

- The type and amount of information to be used or disclosed is as follows (include dates where appropriate):
 - History & Physical, Discharge Summary, Consult, Progress Note, Operative Report, X-rays, Lab Dates: _____
 - Entire Record Dates: _____
 - Other (specify) _____ Dates: _____

- 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 for alcohol and drug abuse. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

The following information is protected by State and Federal Law. If this information applies to you, please indicate if you would like this information released/or obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	_____ Yes _____ No	Dates: _____
HIV Testing and Results	_____ Yes _____ No	Dates: _____
Mental Health or Psychotherapy Records	_____ Yes _____ No	Dates: _____

- This information may be disclosed to and used by the following individual or organization:**

Name	Address	Purpose	Date	Type of Information
A				
B				
C				

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization is effective as of the date set forth below. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 120 days from the date that I sign it.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Pinnacle Health Hospitals may not condition treatment on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by federal patient privacy regulations. I understand that any disclosure of information carries with it the potential for information disclosed pursuant to this authorization to be redisclosed by the recipient and no longer be protected by federal patient privacy regulations. If I have questions about disclosure of my health information, If I have questions about disclosure of my health information, I may contact the Compliance and Privacy Officer at Pinnacle Health, P.O. Box 8700, Harrisburg, PA 17105 or by phone (717) 231-8211. I understand the nature of this authorization. The federal privacy regulations referred to in this document may be found at 45 CFR 160 and 164.

Signature of Patient or Personal Representative

Date

If Signed by Personal Representative, Describe Personal Representative's Authority

Signature of Witness



PATIENT IDENTIFICATION

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

Patient (is a minor _____ years of age) or is unable to consent because: _____

The above named patient is currently unable to provide a signature on this form.

Signature of Parent, Legal Representative (legal guardian,
executor or administrator of the estate) Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

ORAL CONSENT

Only For Persons Physically Unable to Provide a Signature
Whose Records are Being Released Pursuant to the Pennsylvania
Mental Health Procedures Act Regulations

I witnessed that _____ (patient's name) understood the nature of this release,
understood that he/she may orally revoke this consent at any time except to the extent that action has been taken in
reliance upon it and freely gave his/her oral consent.

Witness

Date

Witness

Date



**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION - GENERAL**

PATIENT IDENTIFICATION