

General Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS # (last 4 digits): _____ Medical Record #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below

2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service: _____

- | | | |
|---|---|--------------------------------|
| Referral Sheet | Home Health Aide Daily Activity Sheet | Discharge Summary |
| Wound Flow | Clinical Professional Notes | Medication Profile |
| Discharge Instructions | Behavioral Health Information | Lab Results |
| Substance Abuse Information | Plan of Treatment | Entire Record |
| Follow-up Assessment/ OASIS/60 Summary | Human Immunodeficiency Virus (HIV) Information | OTHER: please specify _____ |

4. I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e)); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).

5. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____

Address: _____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- Sharing with other health care providers as needed Other (please describe):

7. 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 medical record 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. An oral request for revocation can be accepted in special circumstances.

8. Unless I specify differently, this authorization will expire six months from the date signed below:

9. With the exception of Behavioral Health, substance abuse or HIV information, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. Any information disclosed containing Behavioral Health, substance abuse or HIV information is protected under State regulations limiting the recipient's right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or health care agent/health care representative

Date

Relationship to patient, if signed by health care agent/representative

Signature of witness* (2 witnesses required for verbal consent)

Date

I have been offered a copy of this Authorization Form
Patient (or agent/representative) identification verified

Accept Refuse
Yes No

I would like to receive the records requested in an electronic format

Yes No