WELLSPAN HEALTH

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

MR # _____

ACCT # _____

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

Patient Name: _____ **Maiden Name:** _____

Date of Birth: _____ **Last 4 numbers of your 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**
- ☐ **Abstract of Hospital Medical Record** (History & Physical, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)
- ☐ **Individual Results Listed Above (please specify):**_____
- ☐ **Immunization Record**
- ☐ **Read Access for a WellSpan Employee**
- ☐ **Other** (Please Specify):_____

Behavioral Health Reports:

☐ **Social History**	☐ **Treatment Plan**	☐ **Referral/Treatment Summary**
☐ **Client Data Form**	☐ **Aftercare Instructions**	☐ **Notification of Admission**
☐ **Admission Evaluation**	☐ **Psychological Evaluation**	

☐ **Other** (Please Specify):_____

For the purpose of:

☐ **Further Medical Care**	☐ **Personal**	☐ **Insurance Eligibility / Benefits**
☐ **Changing Physicians**	☐ **Legal Investigation / Action**	

☐ **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 follow information. If this information applies to you, please indicate if you would like this information release/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: _____

- I understand that if the use/disclosure of these records is for my own use, I may be charged for the pages in accordance with Pennsylvania Department of Health Regulations and 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 if authorizing access to my medical record to a WellSpan Employee will allow the employee the complete access to all of my medical information. This DOES NOT authorize the WellSpan Employee to disclose, modify or provide any official medical advice on my behalf.
- 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 90 days, unless otherwise specified, not to exceed 1 year from date of signature.** _____

_____ _____

Signature of Patient/Agent Date

_____

Name of Patient (Please Print)

_____ _____

Signature of Witness Date

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

If signed by person other than the patient, state relationship and authority to do so:

Patient is ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

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

VERBAL AUTHORIZATION

IF PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE AND HAS RECORDS THAT ARE BEING RELEASED PURSUANT TO THE PENNSYLVANIA MENTAL HEALTH PROCEDURES ACT REGULATIONS, COMPLETE THE FOLLOWING:

We, the undersigned, do verify that the above Authorization has been read to the client and that s/he 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

Fax Number : (717) 812-8119

Requests for health information and invoices are processed by MRO