Authorization for Disclosure of Health Information

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number
Information From:		Fax Number:

Disclosed Information: (check all items to be released)

☐ **ENTIRE RECORD** (INCLUDES "SPECIAL RECORDS" BELOW UNLESS OTHERWISE INDICATED)

☐ Discharge Summary	☐ Operative Report	☐ Lab Reports	☐ Consultations
☐ Discharge Instructions	☐ ER Record	☐ EKG/Cardiac Studies	☐ Medication Orders
☐ History and Physical	☐ X-Ray/Imaging Reports	☐ Progress Notes	☐ Physician Orders

☐ Other (please specify) _____

Covering the period(s) of care (list applicable dates of treatment) _____

Special Records:

I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below.

AIDS/HIV Information	Psychiatric Care Treatment	Treatment for Drug or Alcohol Use/Abuse
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

Information To Be Provided To:

HERITAGE FAMILY HEALTH, PC
1297 Schaeffer Road
Newmanstown, PA 17073
Phone: (717) 949-4138 Fax: (717) 949-4140

Purpose/Use Of The Requested Information:

☐ Transfer/ongoing continuity of care
☐ Sharing with other healthcare providers
☐ Other (please describe) _____

Authorization

I authorize my healthcare information to be released for the purpose and in the manner herein described.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.

My refusal to sign this authorization will not affect my ability to receive treatment.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

_____ _____ _____

Signature of Patient/Guarantor/Personal Representative | Print Name | Date

Relationship of Guarantor/Personal Representative to Patient: _____

If Authorization is signed by someone other than the patient, please state reason. _____

PLEASE SEE NOTES ON REVERSE

Instructions for Completing
The Authorization for Disclosure of Health information

1. Please complete all sections of the Authorization for Disclosure of Health information.

2. The patient or legally authorized representative must sign and date the form.

3. Generally, only a patient may authorize release of his/her medical information. Exceptions are as follows:
   a. Authorization of minors: If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.

   b. Emancipated minors: An emancipated minor is a minor under the age of 18, who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.

   c. A minor who has been diagnosed with a venereal disease, a substance abuse problem, or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.

   d. Authorization after death: An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.

   e. Authorization of the incompetent patient: If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.

Heritage Family Health, PC reserves the right to request proof of representation.

Please Note

1. Heritage Family Health, PC may charge for copying records in accordance with Pennsylvania law, as applicable.

2. Heritage Family Health, PC will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

3. Heritage Family Health, PC will make reasonable efforts to comply with this request within thirty (30) days. If unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.

4. Heritage Family Health, PC may deny this request under limited circumstances as provided for under federal law. Heritage Family Health, PC will notify you if it denies your request to access or obtain a copy of the requested information. If it denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact Heritage Family Health, PC Privacy Officer at the following address:

   Heritage Family Health, PC
   Privacy Officer
   1297 Schaeffer Road
   Newmanstown, PA 17073