WASHINGTON HEALTH SYSTEM
155 Wilson Avenue Washington, PA 15301
Phone 724-223-3160

Medical Record #_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or is unable to sign, the parent or guardian must provide authorization.

Patient Name _____ Date of Birth _____

Address _____ Soc. Sec. Number_____

City _____ Phone number_____

State _____ ZIP_____ Contact_____

E-mail Address _____

I HEREBY AUTHORIZE WASHINGTON HEALTH SYSTEM TO: ☐ **RELEASE TO** ***OR*** ☐ **OBTAIN FROM**

Party to release/receive the above named individual's health information:

Name _____

Address _____

City_____State_____ZIP_____

Fax _____

INFORMATION TO BE RELEASED/OBTAINED:

Date	Type of Admission		Records
_____	Inpatient	o	Discharge Summary
_____	Emergency Dept.	o	Operative Report
_____	Outpatient Surgery	o	Medical Portion
_____	Outpatient Diagnostic	o	Other (specify) _____

This information will be used for the following purpose:

☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other_____

Please be aware that Health Care Facilities are authorized by Pennsylvania State Law to charge for the reproduction of medical records and that charges may be associated with this request.

- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the Medical Records Department of Washington Health System. I understand that this notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The Hospital may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate.

_____ _____/_____

Signature of Patient or Personal Representative — Date / Time

_____ _____

Printed Name of Patient or Personal Representative **(if applicable, proof required)** — Relationship to Patient

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

FOR OFFICE USE ONLY

REQUEST TAKEN BY: _____ DATE: _____

RECORDS RELEASED BY: _____ DATE: _____

CD/DVD CREATED BY: _____ DATE: _____

Identification verified by:

☐ Patient Known to Staff

☐ Photo ID Obtained

☐ Signature Checked

INFO SENT

FS	PR	OR	EK	OP
DS	PO	LB	NN	AB
HP	CO	XR	ER	CC

OT_____DATE_____INIT_____