

WHS-Greene
 Medical Records Dept.
 350 Bonar Avenue
 Waynesburg, PA 15370
 Phone: 724-627-2684

WHS-Washington
 Medical Records Dept.
 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 _____ Appointment Date _____
 City _____ Phone number _____
 State _____ ZIP _____ Contact (if other than patient) _____
 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 _____
 Phone _____ Fax _____

INFORMATION TO BE RELEASED/OBTAINED: (must be completed to properly identify records to be released)

<u>Date</u>	<u>Type of Admission</u>	<u>Records (please check <input checked="" type="checkbox"/> appropriate documents)</u>	
_____	Inpatient	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Imaging (x-ray, CT, MRI, etc) Reports
_____	Emergency Dept.	<input type="checkbox"/> History & Physical/Psych Eval	<input type="checkbox"/> Consults <input type="checkbox"/> Progress Notes
_____	Outpatient Surgery	<input type="checkbox"/> Lab Report/Pathology	<input type="checkbox"/> Operative Report <input type="checkbox"/> Physician Orders
_____	Outpatient Diagnostic	<input type="checkbox"/> ER Dept. Report	<input type="checkbox"/> Medications
			<input type="checkbox"/> 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 Washington or Greene office. 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.

 Patient or Authorized Signature/Relationship (if applicable, proof required) _____
Date / Time

 Signature of Staff Person Obtaining the Consent (Witness) (internal use) _____
Date / Time
Two witnesses are required when a verbal authorization is taken from a patient who is unable to sign. NOT applicable to HIV related information or Drug and Alcohol Treatment Information.

 Witness #1 Date / Time Witness # 2 Date/ Time
This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

FOR OFFICE USE ONLY		<u>Identification verified by:</u>	
REQUEST TAKEN BY: _____	DATE: _____	<input type="checkbox"/> Patient Known to Staff	
RECORDS RELEASED BY: _____	DATE: _____	<input type="checkbox"/> Photo ID Obtained	
CD CREATED BY: _____	DATE: _____	<input type="checkbox"/> Signature Checked	