GUTHRIE

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Read Entire Document Before Signing

Patient: _____ Medical Record #: _____

Date of Birth:_____/_____/_____ SS# : (last 4 digits) X X X - X X - _____

Telephone # : ( ) _____ - _____ Current Address: _____

Alternate phone #: ( ) _____ - _____ City: _____ State: _____ Zip: _____

1. The following organization is authorized to make the disclosure: (mark all that apply)

☐ Robert Packer Hospital Sayre, PA	☐ Corning Hospital Corning, NY	☐ Troy Hospital Troy, PA	☐ Towanda Memorial Hospital Towanda, PA	☐ Guthrie Medical Group PC _____ City, State (List all that apply)

2. Description of information to be disclosed or used

Dates of treatment: From _____ to _____

☐ Discharge Summary	☐ Emergency Department	☐ Clinic Notes
☐ History & Physical	☐ Physical Therapy	☐ Immunization Records
☐ Operative Report	☐ X Ray Reports	☐ Lab Results
☐ Cardiac Reports	☐ Discharge Instructions	☐ Other _____

3. I authorize the disclosure of the above named individual's health information in the following format:
☐ Paper Copy ☐ Electronic (CD/DVD) ☐ Electronic On-Line

4. This information may be disclosed to and used by the following individual or organization:

Name: _____ Telephone:( )_____ Fax:( ) _____

Address:_____
(Street) (City) (State) (Zip)

5. Purpose of disclosure: ☐ Sharing with healthcare provider ☐ Legal ☐ Personal Use ☐ Insurance
☐ Lay Caregiver ☐ Other:_____

6. I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
- I may revoke this authorization at any time in writing, but if I do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
- Once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.
- I may see and obtain a copy of the information described on this form, for a reasonable copy fee.
- The information to be disclosed may include information relating to genetic diseases/testing.

7. This authorization will expire six months from the date of signing unless I request an earlier date or event here: _____

8. Drug, Alcohol, HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. **Do not release**: ☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signature of Patient/Guardian:_____ **Date:**_____/_____/_____

Relationship to Patient: _____

Photo ID required for records to be picked up.
Witness to ID :_____

HSI1000-01