AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*** * * PLEASE READ AND COMPLETE ALL ITEMS * * ***

Please use Form #14014 to
Authorize the Disclosure of Substance Use Disorder Treatment Records

Patient Name: _____ **Alias/Maiden Name:** _____

Date of Birth: _____ **Last 4 of Social Security Number:** _____ **Phone Number:** _____

Address: _____
Street City/Town State Zip Code

I authorize the use/disclosure of health information about me as described below:

☐ Obtain from:

To obtain from: _____ ☐ Disclose to: _____
(*What Hospital/Practice/Service*) **(*Release to What Organization/Practice/To Whom*)**

Address: _____ Address: _____

_____ _____

Fax No.: _____ Phone No.: _____

Fax No.: _____

Share the following information from my medical record: From: _____ To: _____
(Please Specify the Dates of Service)

☐ **Abstract of Hospital and/or Medical Group Records:**
History & Physical, Emergency Department Physician Notes, Discharge Summary, Consultation Reports, Mental Health Notes, Operative & Procedure Reports, Office Visit Notes, Psychiatric and/or Psychological Evals, Laboratory Reports, Imaging Reports, and any other Diagnostic Studies, etc.

☐ **Diagnostic Test Results** (please specify): _____

☐ **Imaging** (please select **one** format): ☐ **CD and Reports** ☐ **Reports Only**

☐ **Billing Statements**

☐ **Complete medical record or other** (please specify): _____

For the **purpose** of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance** ☐ **Legal** ☐ **Other:** _____

I would like the recipient listed above in the "Disclose to" section to receive this information via (please select one):

☐ **Paper** ☐ **CD** ☐ **Secure Email Notification (email address):** _____

- I must provide a valid email address, either my own or that of my designated recipient.
- An email notification will be provided with instructions to retrieve the requested records from a secure portal. These records will only be available as PDF documents on the secure portal for 30 days following the date of the email Notification of Availability.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ☐ Behavioral/Mental Health Services

I understand that **the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, HIV/AIDS, and substance use disorder** (for example, from primary care visits) and that by signing this authorization I am agreeing to the release of such information. I can choose and have the right to have my records released directly to me so that I can review and inspect the materials, including for sensitive information I do not wish to be disclosed to a third party.

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I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

_____ _____

Signature of Patient/Representative * Date

_____

Print Name of Representative and Relationship to Patient *

_____ _____

Signature of Witness Date

_____

Print Name of Witness

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

To comply with the PA Mental Health Procedures Act:
THIS PORTION TO BE COMPLETED WHEN A PATIENT/REPRESENTATIVE IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above Authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

_____ _____

Signature of Witness Date

_____

Print Name of Witness

_____ _____

Signature of Witness Date

_____

Print Name of Witness

PLEASE MAIL OR FAX THIS FORM TO:

WellSpan Health
Health Information Management – Release of Information
50 Wyntre Brook Drive
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119
Email: PatientRequests@wellspan.org

*** * * IMPORTANT: Please send copies of medical records directly to the requesting practice or physician. * * ***

Requests for health information and invoices are processed by: MRO CORPORATION