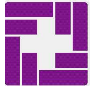

Wayne Memorial Hospital

601 Park Street , Honesdale, PA 18431
570-253-8263
570-253-8637 Fax

Authorization for Disclosure of Health Information

Patient Name:______________________________________ Date of Birth:____________________

Social Security Number:________________________________ Medical Record Number: ____________

I hereby authorize the use or disclosure of the above-named individual's health information as described below.

Persons/Organizations to provide information:
____
____
____
____

Persons/Organizations to receive information:
____
____
____
____

Specific description of information to be disclosed (include dates (s)): ______________________________
____
____

Purpose for disclosing information: ______________________________________
____
____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that if the organization/individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Unless otherwise revoked, this authorization will expire 60 days from the date of signature.

I understand that my health care and the payment for my health care will not be affected if I do not authorize this disclosure. I understand that I will be given a copy of this authorization form, after signing.

______________________________________ ____________________
Signature of Patient/Legal Guardian Date

If signed by legal representative, relationship to patient ______________________________________

______________________________________ ____________________
Signature of Witness Date