Wayne Memorial Hospital
Honesdale, PA 18431

Authorization To Obtain Health Information

* R O I *

Patient Name:_____ **Date of Birth:**_____

Patient Phone Number: _____ Patient Email: _____

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

Persons/Organizations <u>to provide</u> information:

North Penn Cardiovascular Specialists
<u>Haitham Abughnia, MD</u>
401 N. State St. Clarks Summit PA 18411
Fax: (570) 587-7815

Next/Anticipated Appointment Date: _____

Organizations <u>to receive</u> information:
Wayne Memorial Hospital – Mid Valley
601 Park Street Honesdale, Pa 18431
Phone 570-291-7242 Fax 570-291-7243
requestmedicalrecords@wmh.org

Hospital Department/Office:

☐ Cardiology ☐ GI ☐ Gynecology ☐ Internal Med.
☐ Nephrology ☐ Ortho ☐ Neurology ☐ Pulmonology
☐ Surgical ☐ Urology ☐ Mid Valley
☐ Other _____

<u>RELEASE CONTENT</u> (Select all that apply):

Dates of Service(s): _____

☑ Last Two (2) Provider Office Notes**: Dr. Haitham Abughnia, MD**

☑ Last Two (2) ECGs ☑ Last Two (2) Echocardiograms ☑ Last Two (2) Cardiac Catherization
☑ Last Holter Monitor ☑ Last Stress Test (Including Nuclear) ☑ Last Hospital Stay Note

☐ Other (Please Specify Record Type): _____

<u>SPECIALLY PROTECTED</u> I authorize release of information about the following specially protected information if it is contained within the medical record:

☐ HIV ☐ Behavioral Health ☐ Substance Use/Abuse ☐ Sexually Transmitted Diseases

- I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information disclosed in response to this authorization may be subject to re-disclosure by the recipient, and will no longer be protected under the terms of this authorization.
- I understand I have the right to inspect or copy the health information to be used or disclosed as permitted by law.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable).
- I understand that Wayne Memorial Hospital may receive compensation for medical record copying in accordance with Pennsylvania law, 42 Pa.C.S. § 6152

☑ **Purpose of Disclosure**: Continuity of Care

Signature of Patient/Personal Representative: _____ Date: _____

If signed by personal representative, describe relationship to patient: _____

File under Admin-Medical Record Request/Medical Record Release

Affix Patient Label