WAYNE MEMORIAL
HOSPITAL

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS:

Please read these instructions on how to complete the attached form. This form stipulates who you authorize to receive information about you and your treatment at WMH. If you would like to know more about WMH's privacy practices, please refer to the Notice of Privacy Practices available at registration areas, or online at www.wmh.org

RELEASE TO RECIPIENTS

1. **PRINT** your name, date of birth, address and telephone number in the spaces marked.
2. **CHECK** the appropriate boxes to identify to whom you want information about yourself and your treatment at WMH released.
   - ❖ Check "Myself" if you are asking to view your own medical records or receive a copy of them
   - ❖ Be sure to include the address, fax or email where you want the information sent

RELEASE CONTENT

1. Identify the contents of health information you would like released about yourself and your treatment here.
2. Anything NOT listed here will NOT be released. By checking "Complete Medical Records," you are releasing your entire medical record.
3. If you check "OTHER," be sure to list specific items that you want released.

RECORD FORMAT

1. You may request a copy of your medical records in either paper or electronic format; please choose only one.

DELIVERY OF RECORD BY:

1. If you choose email as the method of delivery, be aware that there are **risks** associated with sending patient information via email.
2. **Emails**:
   - ❖ May not be reliable, secure or private.
   - ❖ Can be hacked, sent to the wrong person, lost or subject to other sending errors.
   - ❖ Can be accessed by anyone with access or that gains access to your e-mail account.
   - ❖ Can be read, forwarded, copied, deleted or changed by anyone who has or gains access to your email.
   - ❖ That are deleted can be found again.
   - ❖ Can spread viruses.
   - ❖ E-mail services have a right to save and check e-mail sent through their system.
3. You should not receive your health information via email if people who you don't want to view your medical information have access to your e-mail account

SPECIALLY PROTECTED INFORMATION

1. You MUST specifically request that the specially protected information included in this section be sent to any individual or entity outside of WMH. Check the information you want released to the individuals/organizations listed in the first section of the form.
2. If you are releasing information to more than one individual outside of WMH, AND want to limit sensitive materials to only one of these individuals/entities, then complete a separate Authorization form for that single person/entity.
   - ❖ Note: HIV test results require separate authorizations for each request, as well as each instance of use and disclosure.

AUTHORIZATION EXPIRATION

1. Check either the standard 90-day timeline, or select the timeframe that fits your needs by checking the second box and filling in the dates. This box should be used for clinical trials and/or for patients to specify a shorter timeframe.

REASON FOR DISCLOSURE

1. Please check all the reasons you are authorizing this disclosure of health information.
2. If there is a reason not listed, check "Other" and specify the reason.

CONSENT

1. Please read this section carefully. Sign and date the form if you agree with ALL of the statements.
2. Please return the original to:
   Medical Records Department
   Wayne Memorial Hospital
   601 Park Street
   Honesdale, PA 18431
   Phone: (570) 253-8263
   Fax: (570) 253-8637
3. Keep a copy for your records.

WAYNE MEMORIAL
HOSPITAL

Phone: (570) 253-8263
Fax: (570) 253-8637

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE TO RECIPIENTS

Patient Name _____ **Date of Birth**_____

Address_____ **Telephone**_____

I hereby authorize **Wayne Memorial Hospital** to disclose my specified patient information to the following individuals or entities:

☐ MYSELF (Address above) ☐ OTHER: (please list address, name and contact information below)

_____

_____

_____

_____

RELEASE CONTENT

Dates of Service (s): _____

☐ Radiology Films	☐ Discharge Summary	☐ Consultation Reports
☐ Radiology & Imaging Studies	☐ Operative Report	☐ Lab Reports
☐ Cardiology Reports	☐ History and Physical (H&P)	☐ Emergency Room Records
☐ Good Shepherd Record	☐ PT/OT/Speech/Audiology	☐ Pathology Reports
☐ Wound Care/ Cast Care	☐ Oncology Records	☐ **Complete Medical Record**
☐ **Abstract of Medical Record**	☐ OTHER – List items: _____	

(Face Sheet H&P, Discharge Summary, Consult Reports, Operative Reports, Pathology Reports, Cardiology Reports, Lab Reports, Imaging Reports and Emergency Room Reports)

RECORD FORMAT: (choose one) ☐ Encrypted CD ☐ Paper ☐ Email**

RECORD DELIVERY: (choose one) ☐ Mail ☐ Pick Up ☐ Fax ☐ Secure Email** ☐ Cloud Delivery (Imaging Studies Only)

** Email may not be reliable, secure or private. Please see instructions for more details

Email Address for Record Delivery (Complete ***ONLY*** if requesting record Via Email)																										

SPECIALLY PROTECTED I authorize release of information about the following specially protected information if it is contained within the medical record: (If your entire medical record is being released, check those pieces of highly sensitive health information you authorize released):

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

***This disclosure requires a separate authorization by the patient.**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations

AUTHORIZATION EXPIRATION This authorization is valid (check one):

☐ From today forward for 90 days, **only for information requested on this form**

☐ For patient to indicate a **shorter timeframe only**. (Specify the dates) – From _____ until _____

REASON FOR DISCLOSURE My health information is being released for the following reason(s) - Check all that apply:

☐ Personal	☐ Insurance Eligibility/Benefits	☐ Further medical care
☐ Legal investigation or Action	☐ OTHER (Please specify)_____	

* R O I *

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CONSENT

- 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.

X

_____ _____ _____

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE | DATE | CLEARLY PRINT NAME

X

_____ _____ _____

SIGNATURE OF WITNESS | DATE | CLEARLY PRINT NAME OF WITNESS

If Authorized Representative signs form, please check reason:

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority (Requestor may be asked to provide supporting documentation)**:**

☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate

☐ Power of Attorney for Health Care ☐ Authorized Legal Representative

Original to Medical Record: Copy to Patient

FOR OFFICE USE ONLY

MRN _____

ACCT#_____

Date Received _____ Print name_____

Date ID Verified_____ Print name_____

Date Processed_____ Print name_____

Date Mailed _____ Print name_____