Wayne Memorial Community Health Centers

A Wayne Memorial Health System Affiliate

AUTHORIZATION TO RELEASE, USE, DISCLOSURE AND/OR OBTAIN HEALTH INFORMATION

Patient Name _____ Date of Birth_____ Telephone_____

Address_____

I hereby authorize Wayne Memorial Community Health Centers to release, use, disclose and/or obtain health information about me as described below:

☐ TO OBTAIN FROM

_____

_____

_____

☐ TO RELEASE INFORMATION (list addresses below)

_____

_____

_____

Specific description of information to be disclosed [include dates (s)]: **Dates of Service**: _____

☐ **Complete Medical Record Limited Disclosure (Check only those items of the record to be released)**

☐ Radiology & Imaging Reports ☐ Pathology Reports ☐ Lab Reports ☐ Office Notes

☐ Records Regarding Pain Management ☐ Immunization Record

SENSITIVE MATERIALS I authorize release of information about the following sensitive 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):

____ Behavioral Health notes* ___Substance Abuse History ____ HIV test results* ____ 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 or disclosed for the following reason(s) Check all that apply:

□ Personal □ Insurance Eligibility/Benefits □ Further medical care

□ Legal investigation or Action □ OTHER (Please specify)_____

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 Community Health Centers 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 choose patient status & authority:

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority**:** ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate ☐ Power of Attny for Healthcare ☐ Auth.Legal Represent.