CAMPER INFORMATION

Medical Records & Access

WAYNE MEMORIAL HOSPITAL

601 Park Street, Honesdale, PA 18431

www.wmh.org

WAYNE MEMORIAL HOSPITAL

An Affiliate of Wayne Memorial Health System, Inc.

Dear Camper Family,

Welcome to our corner of northeast Pennsylvania! As we approach another camp season here in Wayne County, we wish you and your families an enjoyable summer season. While we hope your summer activities do not require a visit to Wayne Memorial Hospital for care, we wanted to provide information that may be helpful should you need our services.

Wayne Memorial Hospital is the main hospital serving your camp, and the enclosed packet contains information about accessing our services and your camper's medical records in the event that you need them. It includes forms and instructions for the release of protected health information, information about how to retrieve digital and hard copies of results, reports and images, and how your primary care provider may also access this information. Depending on your camper's age, you may have to complete a PROXY form, which is also in this packet.

We also offer an online PATIENT PORTAL, where you can access important information about your camper's care. This includes lab and radiology reports, doctors' notes and medication lists. The patient portal is called myWMH and you can click here to create an account to access it:

Patient Portal Information - Wayne Memorial Hospital (wmh.org)

Instructions on how to set up the portal are also included in this packet.

Wayne Memorial Hospital and its independent affiliate, Wayne Memorial Community Health Centers, offer emergency care, urgent and walk-in care and physician specialties in surgery, orthopedics, cardiology, nephrology, neurology, obstetrics/gynecology, gastroenterology, pulmonology and more. Our hospital is a Certified Primary Stroke Center and a Level IV Trauma Center with a nearby helipad for life-saving flights.

Again, we hope your camper has a safe, fun, healthy summer stay – and never has to use our services. But if this should happen, please know that our staff is 100% focused on providing the highest quality of care possible. Please visit our website, Wayne Memorial Hospital in Honesdale PA | Community Hospital | WMH.org. And do not hesitate to contact our Community Relations office if you have questions at (570) 253-8422 or email askwmh@wmh.org.

Sincerely,

James Pettinato, BSN, MHSA, CCRN-K
Chief Executive Officer

Patricia Dunsinger
Chief Financial Officer

Chandra Roberts, BSN, MHA, RN
Chief Nursing & Patient Care Officer

Catherine Mignone, MS, SHRM-SCP, SPHR
Chief Human Resources Officer

James Hockenbury, MHA, ACHE
Chief Ancillary Services Officer

Timothy Huber
Chief Facilities & Real Estate Officer

WAYNE MEMORIAL HOSPITAL

An Affiliate of Wayne Memorial Health System, Inc.

MEDICAL RECORDS INFORMATION & ACCESS INSTRUCTIONS

HOW TO REQUEST MEDICAL RECORDS &/OR RADIOLOGY IMAGES

Mail: Wayne Memorial Hospital
Medical Records Department
601 Park Street
Honesdale, Pennsylvania 18431

Phone: (570) 253-8263, Option #1
Fax: (570) 253-8637
Email: requestmedicalrecords@wmh.org
Hours: M-F 7:30 am - 4:30 pm

WAYS TO RECEIVE YOUR CHILD'S MEDICAL RECORDS & /OR RADIOLOGY IMAGES

For Medical Records:
- →Mail – USPS
- →Fax
- →Onsite Pick Up
- →Email

For Radiology Images:
- →Mail – USPS (Images will be on a CD)
- →Onsite Pickup (Images will be on a CD)
- →Email (Link will be sent to requestor)

Hours: M-F 7:30 am - 4:30 pm

PATIENT PORTAL SIGN UP (myWMH)

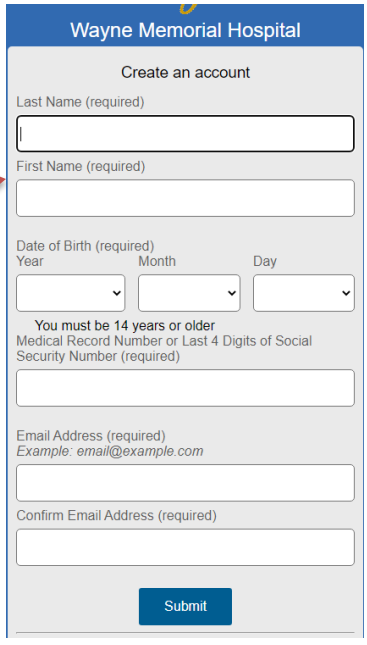
The myWMH **Patient Portal** is an easy, secure, confidential way to access your child's health information online. It gives you real time access to lab results, radiology reports and other hospital reports.

To Sign Up:

- Your child's ***SSN*** must be on file at WMH ***or***
- You must know their WMH ***Medical Record Number*** (starts with an M) ***and***
- WMH must have a ***valid email address*** on file.
- Go to the Wayne Memorial Hospital website: www.wmh.org
- Select the myWMH Patient Portal in the upper right hand corner of your screen.

- Scroll down the page and look for the HOSPITAL PORTAL link.

- This will launch the Sign On page.
- From there select the " Sign Up" button & fill in the information



Please note:
If we do not have an SSN or email address on file,
the parent and/or child must fill out the Portal Proxy form
(Enclosed in this packet).
We will also need to confirm the identity of the person
requesting access to the patient's portal account.

MEDICAL RECORDS FORMS INCLUDED IN THIS PACKET		
FORM NAME	**DIRECTIONS**	**COMMENTS**
Authorization For Release of Protected Health Information	○ Parents must complete this form. ○ It should be filed with the camp to facilitate the record release process should your child need treatment at WMH. ○ This form can be signed by the parent/legal guardian for campers under the age of 18. ○ For patients who are > 18 years of age or are pregnant, **the patient must sign this form** and list the parent we will release the records to.	In the absence of this form, WMH will do everything we can to verify parent identity and relationship to minor child (< 18 years old) over the phone and forgo requiring this document. If we cannot with certainty confirm parent/child relationship, we will ask for this form to be completed and for proof of parental identity.
Authorization For Release of Sensitive Health Information	○ This form is used when there is documentation of ***sensitive information*** specially protected by the State of Pennsylvania. ○ This form, in most cases, must be signed by the patient themselves if they are 14 years of age or older and list the parent we will release the records to ○ **Sensitive Information Includes: HIV, Substance Use/Abuse, Behavioral Health & Sexually Transmitted Disease**	If your child is 14 years of age or older and has documentation in their records of one of these sensitive conditions, or if they are pregnant, WMH will require your child to complete this form and list you as the person that we can release their information to.
Patient Portal Proxy Enrollment Form	○ This form is used to give parents, family and authorized representatives access to a patient's portal account. ○ Children < 14 yrs – needs to be signed only by parent/legal guardian. ○ Adolescents 14-17 yrs - signed by child and parent/legal guardian. ○ Patient 18 years or greater - signed by the patient or legal representative and proxy.	○ Form must be completed in its entirety and all necessary signatures present. ○ For legal representatives, documented proof of relationship may be required (i.e. Power of Attorney, Court Order, etc.)

INSTRUCTIONS FOR ACCESSING/VIEWING RADIOLOGY IMAGES

Required: .zip software (i.e. winzip) or pdf access (i.e. Adobe)

How to Open & View Images on a CD

1. Insert the disc. If auto play is enabled, the EzDicomCDViewer will launch automatically.
    - **Please be patient**. Depending on the size and number of exams, decrypting the disc may take several minutes.
2. If the EzDicomCDViewer **does not open:**
    - Right-click the DVD/CD drive,
    - Select "Open in New Tab," and
    - Double-click the Laucher.exe application.
    - Again, please be patient as launching the viewer may take several minutes.
3. To View Additional Images:
    - Click on the additional frames located on the left-hand side of your screen.
    - See bottom left for additional studies and click on the blue tab containing the name of the study you wish to view.
    - Click the Help icon (image of a question mark) located on the top right-hand side of the screen to display the DMC-EZ (DICOM Media Creators) Web/CD Viewer Users Guide for additional information.

How to Download Images From a CD

1. Follow Steps 1-2 above.
2. Click the 'Export" icon located in the left corner of the EzDicomCDViewer tool bar.
3. Specify the export location on the PC (ex. Desktop or Folder).
4. Select the Format. By default, the images will be exported as JPEG.
5. Click "Export" to save the files to the specified directory.

How to View Images Sent Via an Emailed Link

1. You will be sent an email that includes a link to your child's images.
2. The email containing the link will come from " imaging@wmh.org"
3. You will be sent a separate email with a password to access the link.
4. The email containing the password will come from a member of the WMH Medical Records Department. The email address will end in wmh.org
5. To access the link to the images click on the word "LINK". It is in blue font, capital letters

6. You will be directed to a site titled "FILECLOUD".
7. You will see a " Download File" Icon, click on that.
8. Your antivirus program may suggest not opening this file; it is safe to open.
9. You will be prompted to enter your password.
10. The EZ DICOM CD Viewer should pop up.
11. To view additional images, click on the additional frames on the lefthand side.
12. See bottom left for additional studies. Click on blue tab for that desired study.
13. Click the Help icon (question mark) located on the top right hand side of the screen to display the DMC-EZ (DICOM Media Creators) Web/CD Viewer Users Guide for additional information.

ADDITIONAL MEDICAL RECORD INSTRUCTIONS /INFORMATION	
Sending Records To Other Healthcare Organizations	We do not need patient authorization to share medical records with other physicians involved in the patient's care; we just need to know who the provider is. This is the easiest way to exchange health information with your child's doctors.
Custody	If there are custody issues, please understand that unless the court has ordered differently, generally both parents have rights to their minor child's non-sensitive medical record information. We do reserve the right to ask for proof of custody should we suspect issues.
myWMH **Patient Portal MHealth App**	If your child has been treated or had testing at WMH in the past, WMH recommends that you sign up for the patient portal, myWMH, in advance of the upcoming season so that there is not a delay in obtaining your child's reports. For ease of access you can download the **MHealth** app to your smart phone. **MHealth** is the mobile version of myWMH. It offers secure and convenient access to your health information on your mobile device or tablet. Use your existing myWMH ID and password to get started with **MHealth.**
Paper Records	Requests for "paper copies" of your child's record that result in more than 250 pages will either be: 1. Burned on a CD or 2. Sent as an email attachment if the requestor agrees to this delivery method. 3. Extenuating circumstances preventing the requestor from utilizing CD's or Email will be accommodated.
Emailing Radiology Images	WMH can send you an email with a link to your child's images. Parents can log into the link and download images that are temporarily stored in the cloud. You can also forward the link to your child's healthcare provider. This is particularly useful when images are needed sooner than the USPS mail will allow.

For questions about completion of this form or the myWMH Patient Portal - 570-253-8417

PATIENT INFORMATION:

Name:		Date of Birth:
Street Address:		WMH Medical Record # ("M" Number):
City:		Phone Number:
State:	Zip:	Last 4 of SSN:
Email:		

Please choose the proxy type you are requesting below.

☐ **Adult-to-Child (Age 0-13)** (Access to your minor child's record)	If your child is age 0-13 years: You will be granted full access to your child's portal via a Proxy account.
☐ **Adult-to-Adolescent Child (Age 14-17)** With your child's consent and **their signature below**, you may obtain portal access via a Proxy account	If your child is age 14-17 years, federal and state laws do not permit access to certain types of your child's medical information without your child's consent (such as drug & alcoholic, mental health, reproductive health and certain diseases). This is the law, it is not WMH policy.
☐ **Adult-to-Adult (Age 18 and older)**	The patient or the patient's legal representative must sign this form to provide authorization for WMH to establish a Proxy account.
☐ **Legal Representative** (Must provide supporting documentation) (Check one of the boxes to the right)	☐ Legal Guardian (Court Order) ☐ Power of Attorney for Healthcare ☐ Other: _____

Proxy/Authorized Representative Information:

Name:		Date of Birth:	
Street Address:		Phone Number:	
City:		State:	Zip:
Email:			

Patient: I understand that:

- Granting proxy access is voluntary. I am not required to grant another person access to my portal account.
- I am granting this person access to my personal health information in the form of proxy portal account.
- I may terminate this Proxy's access to my patient portal account at any time by contacting WMH.

Proxy/Authorized Representative: I understand that:

- I have access to this patient's personal health information. I may not share my login or password with another person.
- It is my responsibility to select a confidential login name and password, to maintain this data in a secure manner and to change this password or contact WMH immediately if I believe it may have been compromised in any way.
- Any access to the myWMH Patient Portal is provided as a convenience to patients and their proxy/authorized representatives. WMH has the right to revoke this access at any time, for any reason.
- It is my responsibility to ensure that my e-mail address is current at all times. I understand that if my email is not current, I will not receive notification of messages regarding this patient.

By signing below, I acknowledge that I have read and understand this Patient Portal Proxy enrollment form and I agree to its terms. I choose to designate the person named above as my Proxy/Authorized representative thereby allowing them to access my medical record information via the myWMH Patient Portal account.

Signatures:

Signature Of Patient:		Date:
Relationship to Patient	☐ Parent ☐ Legal Guardian ☐Power of Attorney ☐ Other: _____	
Signature Of Proxy:		Date:

Requirements for access to a patient's portal account:

- Adult-to Adult Proxy must be submitted by the patient and signed by both parties.
- Adult-to-Adolescent Child can be submitted by the parent but must be signed by both parent and child
- Adult-to-Child can be submitted by the legal guardian and requires only the legal guardian's signature.
- If proxy requestor is the Power of Attorney, appropriate documentation must be provided.
- If patient is unable to complete this form, please contact the Wayne Memorial Hospital Medical Records Department at 570-253-8417
- Both the patient and the Proxy must provide a valid email address.

Revocation of Access: Reasons WMH would revoke proxy portal access:

- Change in guardianship for minors
- Adoption
- Child turns 14 years of age (Adult to Adolescent form will need to be completed)
- Child advised WMH of emancipation
- Court ordered custody or power of attorney change
- Misuse of portal account

Procedures:

1. Complete the Patient Portal Proxy Enrollment Form: All information must be entered as indicated to successfully process your request. If the information does not match our records, we will contact you. The information you provide is confidential and processed through secure internet servers.
2. Email Link: You will receive a myWMH Username and Password information via e-mail. Upon validating your submission, a one-time User Name, Password and login instructions will be emailed to you. This email link will be valid for 7 days once received.
3. Activate your account: When you receive your user name and password, return to the myWMH Patient Portal via the link provided and complete the steps to activate your account.
4. Self-Enrollment: In order to self-enroll the patient must have an email address on file. Having an SSN on file is helpful if the patient does not know their WMH Medical Record Number ("M" number)
    - Medical Record Number (MRN): Each WMH patient has a unique MRN. Your Wayne Memorial Hospital Medical Record Number is the number preceded by the letter M.
    - You do not have to include the zeros following the letter M (Example: M000302232 is entered as M302232).
    - Your medical record number can be found on most medical record information from WMH.
    - It will be located on the patient label affixed to these documents. If you cannot locate it, call the Medical Record Department at 570-253-8417 Monday through Friday 8:00 am – 4:00 pm.
5. Shared Access: Patients that have their own myWMH Patient Portal account can invite other people to view their portal information. This is done using the myWMH "Share Access" feature.
6. Legal Representative: You must notify Wayne Memorial Hospital immediately of any change in your legal representation (e.g. Power of Attorney).

WAYNE MEMORIAL HOSPITAL

Phone: (570) 253-8263
Fax: (570) 253-8637
Email: requestmedicalrecords@wmh.org

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): _____

☐ **Complete Hospital Medical Record** ☐ **Abstract Hospital Medical Record*** ☐ **WMH Physician Office Notes** (Specify Which Office/Provider):

☐ Radiology Images	☐ Discharge Summary	☐ Consult Reports	_____
☐ Radiology Reports	☐ Emergency Room Records	☐ Inpatient Rehab	_____
☐ Cardiology Reports	☐ History and Physical (H&P)	☐ Operative Report	_____
☐ Lab Reports	☐ PT/OT/Speech/Audiology	☐ Pathology Reports	_____
☐ Wound Care	☐ Infusion Clinic Records		

☐ **OTHER** – List items: _____

*Face Sheet H&P, Discharge Summary, Consult Reports, Operative Reports, Path Reports, Cardiology Reports, Lab Reports, Radiology Reports and ER Provider Report

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) _____

WAYNE MEMORIAL
HOSPITAL

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 PERSONAL REPRESENTATIVE | DATE | CLEARLY PRINT NAME

X

_____ _____ _____

SIGNATURE OF WITNESS | DATE | CLEARLY PRINT NAME OF WITNESS

If Personal 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 ☐ Personal 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_____

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
   - ❖ 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:
   WMH Medical Records Department
   601 Park Street
   Honesdale, PA 18431
   Phone: (570) 253-8263
   Fax: (570) 253-8637
   Email: requestmedicalrecords@wmh.org
3. Keep a copy for your records.

AUTHORIZATION FOR RELEASE, USE, AND DISCLOSURE OF SENSITIVE 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
   - ❖ 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.

AUTHORIZATION FOR RELEASE, USE, AND DISCLOSURE OF SENSITIVE INFORMATION

RELEASE TO RECIPIENTS

Your Name _____ **Date of Birth**_____

Address_____ **Telephone**_____

I hereby authorize **Wayne Memorial Hospital** to release, use, and disclose health information about me as described below to the following individuals or entities:

☐ MYSELF ☐ OTHER (list addresses below)

_____ _____

_____ _____

_____ _____

SENSITIVE MATERIALS I authorize release of information about the following sensitive information if it is contained within the medical record: ☐ HIV test results

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.

☐ 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 Hospital may receive compensation for medical record copying in accordance with Pennsylvania law, 42 Pa.C.S. § 6152.

X

_____ _____ _____
PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE DATE CLEARLY PRINT NAME

X

_____ _____ _____
SIGNATURE OF WITNESS DATE CLEARLY PRINT NAME OF WITNESS

Original to Medical Record: Copy to Patient

For Hospital Use Only:

MRN _____Date Received _____Date ID Verified_____Date Processed_____Date Mailed_____

WAYNE MEMORIAL
HOSPITAL

An Affiliate of Wayne Memorial Health System, Inc.