Physician Practices Records Management
95 Leonard Ave. 4th Floor
Washington. PA 15301

WASHINGTON HEALTH SYSTEM

Phone: (724) 229-2657
Fax: (724) 579-1596

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or physically unable to sign, the parent or legal guardian must provide authorization.

Patient Name:_____ Date of Birth:_____
Address:_____ Soc. Sec. Number:_____
City:_____ Phone Number:_____
State:_____ Zip:_____ E-mail:_____

I HERE BY AUTHORIZE WASHINGTON HEALTH SYSTEM TO:

Obtain Records From:	
Name:	
Address:	
Phone:	

Release Records To:	
Name:	
Address:	
Phone:	

FORMAT OF RECORD: **A PAPER COPY** *or* **ELECTRONICALLY** (not MAC compatible)

INFORMATION TO BE RELEASED/OBTAINED:

All of the Below	Consultation Reports	Lab Data	Last 3 Years of Progress Notes
Problem List	Immunization Record	Cardiology Data	Last Documented Mammogram, Pap, Colonoscopy
Medication List	Radiology Data	Allergy List	Other:_____

DATES OF SERVICE REQUESTED: From: _____ to _____

*THIS INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSE:*_____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: _____ **Drug/Alcohol** **HIV/AIDS** **Mental Health**

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

- I understand that there may be information in my health record information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the records department to the WHS Physician Practices Records Management office. I understand that notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The WHS Physician Practices Records Management department may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estates into probate.

_____ _____
Patient or Personal Representative Signature Date / Time

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient (if applicable)