Emmitsburg Osteopathic Primary Care Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize ________________________
(Practice Name)

□ to obtain from: ☐ disclose to:

Address: ________________________________ Address: ________________________________

________________________________ ________________________________

The following information from my medical record (*Please specify visit dates)*

Please check as many as apply

□ Office/Progress Notes ☐ History & Physical Examinations ☐ X-ray, Imaging Reports
□ Hospital Discharge Summary ☐ Records from Other Providers (*please specify)* ☐ Laboratory Reports
□ Consultations __________________________ ☐ Cardiac/EKG Reports
□ Other *(please specify)*
____

The purpose of for disclosing the above information is indicated by a check mark in one of the boxes below:
☐ Continuing Care ☐ Relocation ☐ Insurance ☐ Legal ☐ Other *(please specify)* ____________

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the Office Manager of this office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

The signing of this authorization is not a condition for providing treatment.

I understand that if the organization authorized to receive the information is not a health plan or health care provider; the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed per Pennsylvania state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists. Records **NOT** to disclose: □ HIV information; □ Mental health services; □ Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of this document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE SIGNED, UNLESS OTHERWISE SPECIFIED BY THE PATIENT:

______________________	______________________	____________
Print Patient's full name	*Signature of Patient/Responsible party*	*Date*
Patient's date of birth	*Relationship to patient*	
Patient's social security number	*Witness Signature*	*Date*