AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORD NUMBER

Clearfield Hospital • P. O. Box 992 • 809 Turnpike Ave • Clearfield, PA 16830 • 814-765-5341

PATIENT NAME

OTHER NAME

PHONE NUMBER	**BIRTH DATE**	SOCIAL SECURITY	
ADDRESS	CITY	STATE	ZIP CODE

I HEREBY AUTHORIZE RECORDS TO BE RELEASED FROM: _____

INFORMATION TO BE USED OR DISCLOSED: ☐ PATH Slides ☐ Imaging Films ☐ Home Health/Hospice ☐ Entire Medical Record

☐ DS/H&P ☐ Prenatal ☐ Consults ☐ OR/PATH ☐ Labs/Pap Smear ☐ Imaging ☐ EKG/Scans ☐ ER Visits

☐ OP Visits ☐ Face Sheet ☐ MAR ☐ Autopsy Reports ☐ Other _____

☐ Psychiatric Evaluation _____ Initial ☐ Drug/Alcohol Records _____ Initial ☐ Social/Family History Information _____ Initial ☐ HIV Test Results _____ Initial

DATES:

INPATIENT _____ _____ EMERGENCY ROOM _____ _____

OUTPATIENT _____ _____ CLINIC _____ _____

WHO IS AUTHORIZED TO RECEIVE THIS INFORMATION:
PERSON OR ORGANIZATION AND ADDRESS/PHONE NUMBER:

FOR THE PURPOSE OF:

I understand the following:

- That my health record(s) will not be released or obtained by Clearfield Hospital unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items indicated will be released.
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have a right to revoke this Authorization form at any time by sending a written request to the entity where the authorization was provided.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care, and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.
- The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (1) to provide research-related treatment to me, or (2) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

_____ **DATE OF SIGNATURE** _____ **EXPIRATION DATE**

_____ **PATIENT'S SIGNATURE** _____ **WITNESS**

_____ **SIGNATURE OF PERSONAL REPRESENTATIVE** *(WHEN APPLICABLE)* **RELATIONSHIP TO PATIENT**

_____ *(REASON FOR PATIENT NOT SIGNING)*

HEALTH INFORMATION MANAGEMENT USE ONLY

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