

ENDLESS MOUNTAINS HEALTH SYSTEMS



Endless Care & Concern TSS

EMHS
100 Hospital Drive
Montrose, PA 18801

570-278-3801 ext. 1167 & 1168
Fax: 570-278-6438 or 4827 Medical Records
endlesscare.org

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Authorization to Disclose Health Information

(Please allow a minimum of 2 weeks for processing request)

Notice: There will be a charge for copying records - 50¢ per page

Patient Name: _____ Address: _____

Date of Birth: _____ Telephone#: _____

I authorize the use or disclosure of the above named individual's health information as described below.

I REQUEST MY RECORDS TO BE: Mailed
(check which one) Fax'd Fax# _____
 Picked up by _____
(pickups will be held for 2 weeks and then destroyed)

(We need FULL address)

(We need FULL address)

FROM: _____ TO: _____

Address: _____

To be used for the purpose of: _____

PLEASE SEND THE FOLLOWING: (include dates where appropriate)

- | | | | |
|--|-------------|---|------------|
| <input type="checkbox"/> copy of clinic notes | dates _____ | <input type="checkbox"/> most recent discharge summary | date _____ |
| <input type="checkbox"/> copy of hospital record | dates _____ | <input type="checkbox"/> laboratory results | date _____ |
| <input type="checkbox"/> immunization record | | <input type="checkbox"/> x-ray and imaging reports date | _____ |
| <input type="checkbox"/> most recent history and physical date | _____ | <input type="checkbox"/> x-ray films | date _____ |
| <input type="checkbox"/> Other | _____ | | |

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the release of protected health information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

(initials) My evaluation, testing, diagnosis or treatment for **alcoholism and/or drug abuse or dependence** may be released to the requestor listed above.

(initials) My evaluation, testing, diagnosis or treatment concerning my **mental health/rehabilitation** may be released to the requestor listed above.

(initials) My testing, diagnosis or treatment for **HIV/AIDS** may be released to the requestor listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will *expire in six months*.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Director. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.534. I understand I have a right to receive a copy of this authorization upon request.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

At pickup Identification Checked by _____

INFORMATION IS CONFIDENTIAL. IT IS PROVIDED AS AUTHORIZED BY THE PATIENT. NOT FOR REDISCLOSURE.

Physicians providing care are not employees of Endless Mountains Health Systems.