PENN STATE HEALTH ST. JOSEPH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ **St. Joseph Medical Center (hospital)** ☐ **St. Joseph Medical Group (physician practices)** ☐ **St. Joseph Family & Women's Care**

Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.

WHO

Patient Name: _____ Date of Birth: _____/_____/_____ SSN #: (last 4) _____

AKA or Maiden Name: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____

Email _____ Identification Verified ☐

WHERE

Provider Records from:	**Where you would like records sent to:** ***Please complete all fields even if you would like the records faxed. Larger files cannot be faxed & PSHSJ will need a complete mailing address.***
Doctor or Facility Name: _____	☐ **Self**
Address: _____	Doctor or Facility Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone: (_____) _____ Fax: (_____) _____	City: _____ State: _____ Zip Code: _____
	Phone: (_____) _____ Fax: (_____) _____

WHAT

In order to receive the fastest service please specify the information that is being requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows PSHSJ to provide the quickest turnaround times.

Dates of Service: From _____/_____/_____ To _____/_____/_____

Incident or Injury Date: _____/_____/_____

Specific Information: _____

WHY

Purpose of Disclosure – *Please select one*:

☐ Referral to Specialist ☐ Insurance ☐ Worker's Comp
☐ Legal Investigation ☐ Disability Determination/Claim ☐ Personal
☐ Transfer of Care ☐ 2nd Opinion ☐ Other: _____

LEGAL REQUIREMENTS

You MUST agree or disagree to each of the following. Please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response.

Unless otherwise revoked, this authorization will expire 90 days from the date from which it was originally signed or on the following date _____/_____/_____

My evaluation, diagnosis, and/or treatment records relating to the conditions listed below may be released to the person/entity identified above for the following type of records unless otherwise indicated.

☐ Agree ☐ Disagree AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
☐ Agree ☐ Disagree Psychiatric care and/or psychological assessment
☐ Agree ☐ Disagree Treatment for alcohol and/or drug abuse
☐ Agree ☐ Disagree Mental Health Treatment

Failure to complete this section will automatically imply that you do not authorize the release of these records.

SIGNATURE

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and submitted to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.

_____ Date: _____
Signature of Patient or Authorized Representative and Title