Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

FOR ACCESS, USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. Please complete all items with a *. **Failure to provide all information requested may invalidate this authorization**.

***Patient Name (First, Middle, Last):**
***Date of Birth:**
***Address:**
***Telephone Number:**

***Purpose** of disclosure: (Check one.)

- ☐ My personal use: (complete box below)
- ☐ Continued care
- ☐ Other use (describe): _____

*For **personal use only**, check method of access you desire:

- ☐ **In person.** For review only. (You must schedule an appointment with the HIM Department (Monday – Friday between 7:00 am and 3:30 pm.)
- ☐ **Paper copies** (Note that there will be a charge for the cost associated with copying your records. You will be informed of, and billed for, these charges prior to the release of the copies.)
- ☐ **Email copies. Please indicate a personal email address in the section below titled: *Individual(s) or organization(s) authorized to receive the information*.**

*The **type of information** to be disclosed is as follows: (Check the appropriate boxes.)

- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Report
- ☐ Emergency Department Report
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Laboratory Results
- ☐ Radiology Report
- ☐ Pathology Report
- ☐ Other (specify)
- ☐ All Health Information
- ☐ Radiology CD

*For the following **date(s) of treatment**: (Note: authorization is not valid ***prior*** to care being rendered.)

From date:	**To date:**

*Individual(s) or organization(s) authorized **to use or disclose** the information:

- ☐ **Heritage Valley Beaver** _____
- ☐ **Heritage Valley Sewickley** _____
- ☐ **Heritage Valley Kennedy** _____
- ☐ **Other:**

*Individual(s) or organization(s) authorized **to receive** the information:

Name: _____ **Email:** _____

Address: _____

Telephone: **Fax:**

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***PATIENT RIGHTS:**

I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed it may not be under the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Director of Medical Records or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

_____ _____

Signature of Patient ***Date***

OR

_____ _____

Signature of Patient's Legal Representative **Date**

If signed by Legal Representative, description / relationship to patient:

Note: Proof of legal representation is required.

_____ _____

Signature of Staff Obtaining Consent ***Date / Time***

OR

VERBAL CONSENT

We, the undersigned, attest to the fact that the patient named above is physically unable to sign this release/consent. The signatures below indicate the patient understood the nature of this release/consent and freely gave his/her verbal consent.

_____	_____	_____
Witness Printed Name	***Witness Signature***	***Date***
_____	_____	_____
Witness Printed Name	***Witness Signature***	***Date***

***SENSITIVE INFORMATION:**

☐ **I understand that my medical record may contain information relating to** AIDS, HIV, psychiatric care, and/or treatment for drug and/or alcohol use.

☐ I give consent **for use and disclosure of this type of information:**

_____ _____

Signature ***Date***

☐ **I DO NOT give consent for use and disclosure of this type of information:**

_____ _____

Signature ***Date***

EXPIRATION:

Authorization expiration date **or** event: _____

Note: This authorization is valid for six months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.

CON28641H 5/22