SHARON COMMUNITY HEALTH CENTER
94 W. CONNELLY BLVD.
SHARON, PA 16146

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of:_____ Birth Date: _____ SS#: _____ as described below to: Name/Address/Phone # of Facility and/or person:

Records are requested for the purpose of: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):
   [ ] Inpatient; Dates: _____ [ ] Emergency Room; Dates: _____
   [ ] Outpatient; Dates: _____ [ ] Physician Office/Clinic; Dates: _____

2. Specific information to be released (check all that apply);
   [ ] Consultation Reports [ ] Medical History and Physical Exam [ ] Operative Report
   [ ] Discharge Summary [ ] Medication Administration Records [ ] Pathology Report
   [ ] Diagnostic Tests [ ] Physician Orders [ ] Emergency Dept. Report
   [ ] EKG Report [ ] Progress Notes [ ] Discharge Instructions
   [ ] Psychiatric/Psychological Evaluation [ ] Other (specify) _____

HIV, Mental Health, Drug and Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. **Do Not Release: [ ] HIV [ ] Mental Health [ ] Drug and Alcohol**

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed a year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See page two of this form for additional patient rights and responsibilities.** If applicable, specify other expiration date/event here: _____.

Signature of Patient _____ Date _____
(Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18+ years for outpatient mental health information. A minor may authorize release of D&A treatment information)

*Signature of Parent or Legal Guardian _____ Date _____

* Authorized Representative's Relationship and Authority to act on behalf of Patient: _____

ORAL AUTHORIZATION (for persons physically unable to sign)
Not Applicable to HIV or Drug & Alcohol Treatment Information
I witness that the patient understood the nature of this release and freely gave their oral authorization
Two Witnesses are required

_____ _____ _____ _____
Date Witness # 1 Date Witness # 2

ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

- A disclosure statement, as required by law, will accompany all records released
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the record may re-disclose the information, therefore (1) SCHC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical treatment and I understand that I may be responsible for payment of the claim
- SCHC cannot require me to sign the Authorization in order to receive treatment
- In accordance with 4Pa Code 244.4 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plan or governmental officials shall be restricted to the following: (1) Whether the client is or is not in treatment; (2) The prognosis of the client; (3)The nature of the program; (4) A brief description of the progress of the client; (5) A short statement as to whether the client has relapsed into Drug & Alcohol abuse and the frequency of such relapse.
- I am entitled to a copy of this completed Authorization form

Copy of authorization must be provided to patients when authorization is initiated by SCHC and for all Drug & Alcohol Treatment Patients

[ ] Copy of authorization provided to patient
[ ] Copy of authorization refused by patient

Staff and Copy Use Only

Staff Signature: _____Staff Printed Name: _____
Records Released By: _____ Date Released: _____

[ ] Fee $ _____ [ ] No Fee