# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

WELLSPAN® HEALTH

*** * * PLEASE READ AND COMPLETE ALL ITEMS * * ***

**Patient Name:** _____ **Alias/Maiden Name:** _____

**Date of Birth:** _____ **Last 4 of Social Security Number:** _____ **Phone Number:** _____

**Address:** _____

**I authorize the use/disclosure of health information about me as described below:**

☐ Obtain from:

To obtain from: _____
***(What Hospital/Practice/Service)***

☐ Disclose to: _____
***(Release to What Organization/Practice/To Whom)***

Address: _____

_____

Address: _____

_____

Fax No.: _____

Fax No.: _____

**Share the following information from my medical record:** From: _____ To: _____
***(Please Specify the Dates of Service)***

☐ **Abstract of Hospital Medical Records:**
History & Physical, Emergency Department Physician Notes, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, etc.

☐ **Abstract of Medical Group Records:**
Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress Notes, etc.

☐ **Diagnostic Test Results** (please specify): _____

☐ **Imaging** (please select **one** format): ☐ **CD and Reports** ☐ **Film and Reports** ☐ **Reports Only**

☐ **Billing Statements**

☐ **Grant the following authorized user,** _____, **access to my entire Electronic Medical Record.**
This **DOES NOT** authorize the user to disclose, modify, or provide any official medical advice on my behalf.

☐ **Other** (please specify): _____

For the **purpose** of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Benefits**

☐ **Legal Investigation** ☐ **Billing Inquiries** ☐ **Establish Payment Plan**

☐ **Other** (please specify): _____

**I would like to receive this information via** (please select **one**): ☐ **Paper** ☐ **CD** ☐ **Secure Email Notification**

**Email Address:** _____

- I must provide a valid email address, either my own or that of my designated recipient.
- An email notification will be provided with instructions to retrieve the requested records from a secure portal. These records will only be available as PDF documents on the secure portal for 30 days following the date of the email Notification of Availability.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ☐ AIDS/HIV Related Information and/or Testing; ☐ Behavioral/Mental Health Services; ☐ Drug and/or Alcohol Treatment.

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**I understand the following:**

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

_____ _____

Signature of Patient/Representative * Date

_____

Print Name of Representative and Relationship to Patient *

_____ _____

Signature of Witness Date

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

**THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:**

We, the undersigned, do verify that the above Authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

**Verbal consent requires the signatures of two witnesses:**

_____ _____

Signature of Witness Date

_____ _____

Signature of Witness Date

**PLEASE MAIL OR FAX THIS FORM TO:**

WellSpan Health
Health Information Management – Release of Information
912 South George Street
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119

*** * * IMPORTANT: Please send copies of medical records directly to the requesting practice or physician. * * ***

Requests for health information and invoices are processed by: