



Medical Record # _____
 Mail Out Date: _____
 Pick-up Date: _____



MR.AFROI

AUTHORIZATION FOR RELEASE OF INFORMATION

Entity: Please check the appropriate box and provide a copy of this form to the patient.

- | | | |
|--|--|--|
| <input type="checkbox"/> Chambersburg Hospital
112 North Seventh St.
Chambersburg, PA 17201
(717) 267-7158
Attention: HIM Dept. | <input type="checkbox"/> Waynesboro Hospital
501 East Main St.
Waynesboro, PA 17268
(717) 765-3412 option #3
Attention: HIM Dept. | <input type="checkbox"/> Summit Surgery Center
757 Norland Ave.
Chambersburg, PA 17201
(717) 217-6720 |
| <input type="checkbox"/> Summit Cancer Treatment Center

_____ | <input type="checkbox"/> SPS (Practice Name/Address)

_____ | <input type="checkbox"/> Outpatient Behavioral Health
176 S. Coldbrook Ave.
Chambersburg, PA 17201
(717) 267-7480 |

Patient Reference:

Patient's Name: _____ Birth Date: _____
 Address: _____
 Name at Time of Admission Other Than Above: _____
 Phone # _____
 Medical Record Number: _____
 Account Number(s): _____

Information to be Released To:

Specify Name and Address: _____

Verified ID:
 Yes
 No

I am requesting a copy of my own health information Date: _____ Time: _____
 I am requesting to review my own health information. Date: _____ Time: _____

Name of Other Facility Disclosing Information to Summit Health:

Records Involved:

Dates:

<input type="checkbox"/> Inpatient Admission	_____
<input type="checkbox"/> Emergency Room	_____
<input type="checkbox"/> Outpatient Service	_____
<input type="checkbox"/> Other	_____

Nature and Extent of Information to be Disclosed: (Please check and circle all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Adm./Disch.-Final Diagnosis | <input type="checkbox"/> ER/OP Record | <input type="checkbox"/> X-rays, EKGs, EEG's, Echo, Pathology |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Postmortem/Autopsy | <input type="checkbox"/> Lab Reports, PFT, Stress Test, Holter Monitor |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Progress Notes/Doctor's Orders | <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Entire copy of Medical Records | <input type="checkbox"/> Therapy Notes- Physical, Occupational & Speech | |
| <input type="checkbox"/> Abstract: (History & Physical, Discharge Summary, ER Report, Consult Report, Lab Results, Operative Report, Pathology Report, X-ray Results) | | |
| <input type="checkbox"/> Radiology Images: _____ | | |
| <input type="checkbox"/> Other - Specify: _____ | | |

I acknowledge receipt of original radiology images and I understand that these images are the property of the facility named above. I agree to return these images to the facility named above.

Please Note: All patients should consult their physician for information regarding the interpretation of their test results.

SEE OTHER SIDE

Original: Record Copy: Patient (Front) SH07920 (R:6/15)

Purpose of Disclosure: _____ Legal _____ Insurance _____ Social Security Disability
 _____ Other - Specify: _____
 _____ Continued Treatment: (Please provide:) _____
 Name & Address: _____

Effective Date of Authorization: _____ Expiration Date of Authorization: _____
 Please note: Behavioral Health Inpatients have a 60-day expiration on authorizations.

SPECIAL AUTHORIZATION: I understand that my medical records may contain alcohol/drug abuse, Human Immune Virus/Acquired Immune Deficiency Syndrome related and/or mental health information. I give special authorization to the health care facility to release this information in my records to the person or organization named above, for reasons outside of continuity of care.

_____ Patient Initials

GENERAL AUTHORIZATION: I understand and acknowledge that this authorization allows the entity outlined above to release all or part of the records indicated above with the exception of the specially protected health information referred to under the Special Authorization section of this form. I understand that, on occasion, general information may be released by telephone or fax.

- (1) I understand that I may revoke this Authorization at any time, except to the extent that action based on this Authorization has been taken, by sending a letter signed by me to: Privacy Officer, Summit Health, 112 North Seventh Street, Chambersburg, PA.
- (2) The entity outlined above may not condition treatment on my agreement to sign this Authorization.
- (3) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipients listed above and may no longer be protected.
- (4) This Authorization is fully understood by me and is made voluntary on my part.

Date Signed: _____ Patient's Signature: _____

Time Signed: _____

Signature of Witness Required _____
 Signature of Parent/Guardian or Legal Representative (if signed by other than patient, state relationship and reason for patient's inability to sign)
 Relationship: _____
 Reason for patient's inability to sign: _____

The following is to be used for verbal consent by a person physically unable to provide a signature (excluding Drug and Alcohol related to treatment program at Chambersburg Hospital, Mental Health, and HIV-related information):

This form has been read and explained to me, I fully understand its contents, and I verbally authorize the release of information describe above.

Date Signed: _____

Time Signed: _____

Witness #1 Printed Name: _____

Witness #2 Printed Name: _____

Witness #1 Signature: _____

Witness #2 Signature: _____

Authorization for Release of Information Original: Record Copy: Patient (Back) SH07920 (R:6/15)