WASHINGTON HEALTH SYSTEM

Women's Health Center, Meadows Landing
80 Landings Drive, Suite 201
Washington, PA 15301
Phone 724-223-3313
Fax 724-250-6023

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or is unable to sign, the parent or guardian must provide authorization.

Patient Name _____ Date of Birth _____
Address _____ Soc. Sec. Number _____
City _____ Phone number _____
State _____ ZIP _____ Medical Record # _____

I HEREBY AUTHORIZE WASHINGTON HEALTH SYSTEM TO: ❒ **RELEASE TO** ***OR*** ❒ **OBTAIN FROM**

Party to release/receive the above named individual's health information:

Name _____
Address _____
City _____ State _____ ZIP _____

INFORMATION TO BE RELEASED/OBTAINED:

Type of Admission	Date of Service	Records
☐ Inpatient	_____	_____ Discharge Summary
☐ Emergency Dept.	_____	_____ Operative Report
☐ Outpatient Surgery	_____	_____ Medical Portion
☐ Outpatient Diagnostic	_____	_____ Other: _____

THIS INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSE: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the Medical Records Department of Washington Health System. I understand that this notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The Washington Health System may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate.

_____ / _____
Signature of Patient or Personal Representative — Date / Time

_____ _____
Printed Name of Patient or Personal Representative (if applicable) — Relationship to Patient

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

FOR OFFICE USE ONLY

REQUEST TAKEN BY: _____ DATE: _____
RECORDS RELEASED BY: _____ DATE: _____
PROCESSING FEE $_____

Identification verified by:
☐ Patient Known to Staff
☐ Photo ID Obtained
☐ Signature Checked