WHS-Greene
☐ **Medical Records Dept.**
350 Bonar Avenue
Waynesburg, PA 15370
Phone: 724-627-2684

WASHINGTON HEALTH SYSTEM

Medical Record #____________________

WHS-Washington
☐ **Medical Records Dept.**
155 Wilson Avenue
Washington, PA 15301
Phone: 724-223-3160

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 ______________________________ Appointment Date ______________________

City ______________________________ Phone number ______________________

State ____________________ ZIP __________ Contact ***(if other than patient)*** ______________________

E-mail Address ______________________________

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 __________

Phone ______________________ Fax ______________________

INFORMATION TO BE RELEASED/OBTAINED: ***(must be completed to properly identify records to be released)***

Date	Type of Admission	Records (please check ✓ appropriate documents)		
________	Inpatient	☐ Discharge Summary	☐ Imaging (x-ray, CT, MRI, etc) Reports	
________	Emergency Dept.	☐ History & Physical/Psych Eval	☐ Consults	☐ Progress Notes
________	Outpatient Surgery	☐ Lab Report/Pathology	☐ Operative Report	☐ Physician Orders
________	Outpatient Diagnostic	☐ ER Dept. Report	☐ Medications	

☐ Other (specify)______________________

This information will be used for the following purpose:

☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other______________________

Please be aware that Health Care Facilities are authorized by Pennsylvania State Law to charge for the reproduction of medical records and that charges may be associated with this request.

- 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 Washington or Greene office. 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 Hospital 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.

____ __________/__________
Patient or Authorized Signature/Relationship ***(if applicable, proof required)*** Date / Time

____ __________/__________
Signature of Staff Person Obtaining the Consent (Witness) *(internal use)* Date / Time

Two witnesses are required when a verbal authorization is taken from a patient who is unable to sign. NOT applicable to HIV related information or Drug and Alcohol Treatment Information.

____________________ __________ ____________________ __________
Witness #1 Date / Time Witness # 2 Date/ Time

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: __________	☐ Patient Known to Staff
RECORDS RELEASED BY:	__________	DATE: __________	☐ Photo ID Obtained
CD CREATED BY:	__________	DATE: __________	☐ Signature Checked

Identification verified by: (see right column)