WHS-Greene ☐ Medical Records Dept.

CD CREATED BY:

350 Bonar Avenue Waynesburg, PA 15370 Phone: 724-627-2684

	WASHINGTON HEALTH SYSTEM

WHS-	·Washing	ton
Medical	Records	Dept

155 Wilson Avenue Washington, PA 15301 Phone: 724-223-3160

Medical Record #_____

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.

Address	Patient N	Name		Appointment Date		
City	Address					
State						
E-mail Address HEREBY AUTHORIZE WASHINGTON HEALTH SYSTEM TO: RELEASE TO OR OBTAIN FROM					her than patient)	
Party to release/receive the above named individual's health information: Name					, ,	
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 Inpatient Inpa		•			O OR OBTAIN FRO	М
Address						
State	I	Name				
State		Address				
INFORMATION TO BE RELEASED/OBTAINED: (must be completed to properly identify records to be released) Date						
Inpatient						
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 Medications Other (specify)						
Inpatient					-	sea)
Emergency Dept.						
Outpatient Surgery			-		• •	
Outpatient Diagnostic		_ , ,				
This information will be used for the following purpose: Continuing Care/Medical Facility Legal Personal Use Insurance Other					oort LI Physician Orders	
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. Patient or Authorized Signature/Relationship (if applicable, proof required) Patient or Authorized Signature/Relationship (if applicable, proof required) Patient or Authorized Signature/Relationship (if applicable, proof required) Date / Time 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: DATE: Patient Known to Staff Person Applicable for the Judget and that charges may be charge for the reproduction of medical records and that charges may be charged to charge for the reproduction. My refusal will not affect my treatment or payment for my care. The Hospital may receive compensation for the use or disciplination for payment for my care. The Hospital may receive compensation for the use or disciplination for payment for my care. The Hospital my creek the use of information. In the case of a deceased patient:		Outpatient Diagnostic	☐ ER Dept. Report	☐ Medications		
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. Patient or Authorized Signature/Relationship (if applicable, proof required) 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. Patient Known to Staff Patient Known to Staff			r the following purpose:			
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In the case of a deceased patient: I, the undersigned next of kin, certify that assumed responsibility for the disposition of the body of the deceased. Then 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) Patient or Authorized Signature/Relationship (if applicable, proof required) Signature of Staff Person Obtaining the Consent (Witness) (internal use) 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: Description the disposition of the body of the deceased. Then assumed responsibility for the disposition of the body of the deceased. Then has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate. In the case of a deceased patient: I, the undersigned next of kin, certify that assumed responsibility for the disposition of the body of the deceased. Then has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate.	I may revoca	revoke this authorization at any tin ation to the Medical Records Depart	ment of Washington Health System	that would prohibit n	my access to these records or prohibit i	
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	FOR OFFI	CE USE ONLY		· · · · · · · · · · · · · · · · · · ·		
RECORDS RELEASED BY: DATE: Photo ID Obtained						

DATE:

□ Signature Checked