

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

City/State: _____ Medical Record #: _____

I hereby authorize **Schuylkill Rehabilitation Center** to:

release or obtain protected health information to/from:

For the purpose of:

- | | |
|--|--|
| <input type="checkbox"/> Continuation of Medical Treatment | <input type="checkbox"/> Payment of Bill |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Insurance Purposes | <input type="checkbox"/> Personal Access |
| <input type="checkbox"/> At the request of the patient or patient's legal representative | <input type="checkbox"/> Other (specify) _____ |

The information to be released will cover the time period from _____ to _____

SPECIFIC INFORMATION TO BE RELEASED:

- | | | |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Radiology Reports/Films/Images |
| <input type="checkbox"/> Itemized Bills | <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Cardiology Notes |
| <input type="checkbox"/> Emergency Room Notes | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Other (Specify) _____ | | |

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I may revoke this authorization at any time by submitting a written notice, as described in the Notice of Privacy Practices. I understand that if I revoke the authorization it will not have any affect on any actions taken before the receipt of the revocation. I understand that this authorization will expire sixty days after the date of signature or automatically when the records requested on this authorization have been released. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it, except in any case in which re-disclosure is prohibited by state or federal law. I understand that I am entitled to a copy of this authorization.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity to release information related to the testing, diagnosis, and/or treatment for any of the following conditions, please initial in front of the section which describes the type of information to be released.

_____ My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on Initial the signed authorization.

_____ My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be Initial released to the recipient noted on the signed authorization.

_____ My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization. Initial

AUTHORIZATION SIGNATURES

Patient Signature _____ Date: _____ Time: _____

Witness Signature _____ Date : _____ Time: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: _____

Signature: _____ Relationship: _____ Date: _____ Time: _____

(Parent/Legal or Personal Representative)

WitnessSignature: _____ Date: _____ Time: _____

*****Copy of Completed Authorization Form Must Be Given To the Patient*****

Schuylkill Rehabilitation Center

Authorization to Release/Disclose Health Information

Release Expires On: _____