AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize X_____ to release information from the record of:

X_____; X_____; X_____
Patient Name | Date Of Birth | SSN/MR #

Information requested to: (Where do the records need to be sent)

Windber GYN Associates — 600 Somerset Avenue
Practice/Physician Name — Street Address

Windber | PA | 15963 | (814) 467-3176 | (814) 467-3177
City | State | Zip Code | Phone Number | Fax Number

Purpose of Disclosure: (Please select one)

____ Treatment ____Personal ____Legal ____Other _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):

____ Inpatient; Dates: _____ ____ Emergency Dept; Dates: _____

____ Outpatient; Dates: _____ ____ Physician Office/Clinic; Dates: _____

2. Specific information to be released (check all that apply):

☐ Consults	☐ Medical History & Physical Exam	☐ Physician Orders
☐ Discharge Summary/Instructions	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☐ Operative Report	☐ Radiology Report
☐ Psychiatric/Psychological Evaluation	☐ Mammography Report	☐ Pathology Report
☐ Emergency Department Report	☐ EKG Report(s)	

☒ ALL Pap smear results, ALL pathology reports, last DEXA, last 2 years of mammogram reports, last office note.

☒ Other,specify:_____

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: ☐ HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here:_____

X _____ _____ _____ _____
Date | Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) | Date | Signature of Parent, Legal Guardian or Authorized Representative *(complete below)

X _____ _____
Date | Witness/Staff Member Signature

*Authorized Representative's relationship and authority to act on behalf of patient: _____

ORAL AUTHORIZATION (for persons unable to sign)
NOT Applicable to HIV or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

_____ _____ _____ _____
Date | Witness #1 | Date | Witness #2

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that they facility/person that receives the records may re-disclose the information, therefore (1) Windber OB-GYN Associates and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My decision to revoke the Authorization does no apply to any release of my records that my have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- Windber OB-GYN Associates cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted ot the following: 1.) Whether the client is or is not in treatment 2.) The prognosis of the client, 3.) The nature of the program, 4.) A brief description of the progress of the client, 5.) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.

Copy of authorization must be provided to patients when authorization is initiated by Windber OB-GYN Associates and for all Drug and Alcohol Treatment Patients.

- ☐ Copy of authorization provided to patient
- ☐ Copy of authorization refused