General Authorization to Use or Disclose Health Information

☐ Mercy Fitzgerald Hospital ☐ Nazareth Hospital ☐ Saint Francis Hospital ☐ St. Mary Medical Center

Patient Name: _____ DOB: ___/___/___ SS# (last 4 digits): _____ Med Recd #: _____

Address: _____ City/State/ZIP: _____ Phone #: _____

1. The following individual(s) or organization(s) are authorized to make the disclosure: _____

2. The type of information to be used or disclosed is as follows: Date(s) of Service: _____

☐ Face Sheet/Registration Sheet
☐ Discharge Summary
☐ ER Record
☐ H&P
☐ Consults
☐ **Behavioral Health Information** _____ Initial
☐ **Substance Abuse Information** _____ Initial
☐ **Human Immunodeficiency Virus (HIV) Information** _____ Initial
☐ Progress Notes
☐ Operative Report
☐ Pathology Report
☐ Medication List
☐ Lab Results
☐ EKG/Cardiology Testing Results
Radiology Results:
☐ On CD ☐ On film ☐ On paper
☐ Discharge Instructions
☐ Home Care Records
☐ Entire Record
☐ OTHER: please specify _____

Information related to treatment for AIDS/HIV, mental health care, or genetic information will not be disclosed unless specifically checked above.

3. If my authorization includes HIV, Psychiatric/Mental Health, or Drug and Alcohol abuse (substance abuse) information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and Alcohol Abuse Control Act -1972 - Act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures Act 1976, section 5100.3-39).

4. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____ Fax: _____

Address: _____

5. This information for which I'm authorizing disclosure will be used for the following purpose:

☐ Sharing with other health care providers ☐ Personal use by patient ☐ Legal ☐ Other (please describe): _____

6. **Format Requested** (Check only one option):

☐ Deliver to MyChart/Patient Portal ☐ CD ☐ Paper ☐ Inspect a copy ☐ Email (if you choose email, insert email address and choose secured or unsecured below.) _____

☐ Secured/encrypted email (access instructions provided) ☐ Unsecured/unencrypted email*

*If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft.

*Please initial if you are requesting unsecured delivery via your personal email listed above. _____ Initial

**If records are unable to be emailed due to size limitations, please select an alternate format: ☐ CD ☐ Paper

**Records provided on CD or Paper will be sent via the United States Postal Service.

7. This authorization will begin on the date signed below and expire on: _____. If no expiration date is specified, this authorization will expire one year from the signature date.

8. I hereby authorize the noted health care facility to use or disclosure the health information as described above. I understand that I may revoke this authorization at any time by sending a written request to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. An oral request for revocation can be accepted in special circumstances.

9. With the exception of AIDS/HIV, Behavioral/Mental Health, and Genetic Information, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. Any information disclosed containing AIDS/HIV, Behavioral/Mental Health, and Genetic Information is protected under State regulations limiting the recipient's right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

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10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or Personal Representative	Date	Relationship to patient, if signed by Personal Representative

Signature of witness	Date

I have been offered a copy of this Authorization Form ☐ Accept ☐ Refuse
Patient (or agent/representative) identification verified ☐ Yes ☐ No
I would like to receive the records requested in electronic format ☐ Yes *(print email below)*

Email (if applicable): _____

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