ENDLESS MOUNTAINS HEALTH SYSTEMS

Endless Care of Concern TSS

EMHS
100 Hospital Drive
Montrose, PA 18801

570-278-3801 ext. 1167 & 1168
Fax: 570-278-6438 or 4827 Medical Records
endlesscare.org

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Authorization to Disclose Health Information

(Please allow a minimum of 2 weeks for processing request)

Notice: There will be a charge for copying records - 50¢ per page

Patient Name: _____ **Address:** _____

Date of Birth: _____ **Telephone#:** _____

I authorize the use or disclosure of the above named individual's health information as described below.

I REQUEST MY RECORDS TO BE: (check which one)
- ☐ Mailed
- ☐ Fax'd Fax#_____
- ☐ Picked up by _____
  (pickups will be held for 2 weeks and then destroyed)

(We need FULL address)

FROM: _____

Address: _____

_____

(We need FULL address)

TO: _____

_____

_____

To be used for the purpose of: _____

PLEASE SEND THE FOLLOWING: (*include dates where appropriate*)

- ☐ copy of clinic notes dates_____
- ☐ copy of hospital record dates_____
- ☐ immunization record
- ☐ most recent history and physical date _____
- ☐ Other _____
- ☐ most recent discharge summary date_____
- ☐ laboratory results date_____
- ☐ x-ray and imaging reports date_____
- ☐ x-ray films date_____

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the release of protected health information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

_____ (initials) My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the requestor listed above.

_____ (initials) My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation may be released to the requestor listed above.

_____ (initials) My testing, diagnosis or treatment for HIV/AIDS may be released to the requestor listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation 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. Unless otherwise revoked, this authorization will *expire in six months.*

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Director. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.534. I understand I have a right to receive a copy of this authorization upon request.

_____ _____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

At pickup Identification Checked by _____

INFORMATION IS CONFIDENTIAL. IT IS PROVIDED AS AUTHORIZED BY THE PATIENT. NOT FOR REDISCLOSURE.

Physicians providing care are not employees of Endless Mountains Heath Systems.