GROVE CITY MEDICAL CENTER
631 N. Broad St. Ext.
Grove City, PA 16127-9703

PHONE NUMBER 724-458-5442 FAX NUMBER (724)_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ MR # _____

DATE OF BIRTH _____ SS # _____

I authorize _____to release information from the hospital records including photocopies relating to my identity, diagnosis, prognosis and/or treatment to:

_____

(Name and address/fax number of person/facility to receive information)

These records are required for the following reason: ❑ Computer access ❑ Continued care
❑ Military ❑ Workers' Compensation ❑ Personal Use ❑ Insurance
❑ Legal ❑ Other _____

INPATIENT

CONSULT _____
DS _____
H&P _____
LAB _____
OR _____
PATH _____
TCC _____
X-RAY _____
OTHER _____

OUTPATIENT

AMB. SURG _____
EKG/EEG _____
ER _____
LAB _____
ONCOLOGY _____
PT _____
RT _____
X-RAY _____
OTHER _____

I understand that the information in my medical records may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

HIV, mental health, and drug and alcohol information contained in the parts of the records indicated above will be released with this authorization unless otherwise indicated.

Do not release: ❑ **HIV** ❑ **Mental Health** ❑ **Drug and Alcohol**

I understand that I have the 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 Medical Records 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.

I understand that once the above information is disclosed it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that the hospital may not condition treatment, payment, enrollment or benefit eligibility on my signing this authorization.

This authorization will expire on _____. **(Not to exceed one year from date of signature.)** If I fail to specify an expiration date or event, this authorization will expire in 90 days from the date on which it was signed.

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PATIENT NAME _____ **DATE OF BIRTH** _____

I understand that I am entitled to a photocopy of this completed authorization.

I understand that I may be charged a fee for photocopies of my protected health information when it is obtained for my own personal use.

I hereby state that I have read and fully understand the above statements as they apply to me. I consent to the release of records for the purpose stated above.

_____	_____
Signature of Patient Date/time	Signature of Parent, Legal Guardian/ Authorized Representative **(copy of document required)** Date/time
_____	_____
Witness Date/time	Witness Date/time (Second witness needed for verbal consent)

PHOTOCOPIES OF THIS FORM ARE CONSIDERED VALID
• A fee may be assessed for photocopying medical records.

_____
SIGNATURE OF STAFF DATE # OF COPIES

Grove City Medical Center staff initial appropriate response below:

Patient provided with a copy of authorization: _____Yes _____No

Identification verified by photo id: _____Yes _____No