



General Authorization to Use or Disclose Health Information

Please check the facility you are requesting information from:

- Magee Main Hospital, Magee Gaspar Outpatient, Magee Riverfront, Magee at Oxford Valley, Magee at Watermark, Outside Facility/Physician

Patient Name: Phone#:

Address: City: State/ZIP:

Date of Birth: SS# (last 4 digits): Medical Record#:

- 1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service:

- Face Sheet, Radiology Results, Discharge Summary, EKG, H&P, Medication List, Consults, Discharge Instructions, Progress Notes, Entire Record, Lab Results, OTHER: please specify

- Behavioral Health Information Initial, Substance Abuse Information Initial, Human Immunodeficiency Virus (HIV) Information Initial

4. I understand that if my authorization includes Behavioral Health, substance abuse or HIV 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).

5. The information identified above may be used by or disclosed to the following individual or organization(s): Name: Address: Fax Number:

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6. This information for which I am authorizing disclosure will be used for the following purpose:

Sharing with other health care providers as needed Other (please describe): _____

7. 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 Services 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.

8. 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.

9. With the exception of Behavioral Health, substance abuse or HIV 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 Behavioral Health, substance abuse or HIV 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.

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

Signature of patient or Personal Representative	Date/Time	Relationship to patient, if signed by Personal Representative
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Signature of Witness	Date/Time
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Verbal Consent - The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his/her consent.

Signature of witnesses 1. _____ 2. _____
Date/Time _____ **Date/Time** _____

I have been offered a copy of this Authorization Form Accept Refuse
Patient (or agent/representative) identification verified Yes No