WELLSPAN HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to ☐ receive from: _____ ☐ disclose to: _____
(Hospital/Program)

_____ _____

_____ _____

the following information regarding my

Please Check (✓)

☐ inpatient care on _____
specify dates of admission/discharge

☐ outpatient care on _____
specify dates of Clinic visits or outpatient procedure

☐ emergency care on _____
specify dates of Emergency Department visits

Please Check (✓)

☐ Complete Medical Record
☐ Admission Record (facesheet)
☐ Discharge Summary
☐ History and Physical Examinations
☐ Consultations
☐ Progress Notes
☐ Physician Orders
☐ Operative Reports
☐ X-Ray, Imaging Reports
☐ Laboratory Reports
☐ Outpatient Pharmacy Reports

☐ Other *(please specify)* _____

_____

The purpose for disclosing the above information is indicated by a check mark (✓) below:
☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other (*(please specify)* _____

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the WellSpan Privacy Officer, York Hospital Medical Records Department, 1001 South George Street, York, PA 17403. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

WellSpan Health may not condition the provision of treatment upon my signing this authorization.

I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed per Pennsylvania state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists. Records **NOT** to disclose: ☐ HIV information; ☐ Mental health services; ☐ Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of the document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE EXECUTED UNLESS OTHERWISE SPECIFIED BY THE PATIENT:

_____

_____ _____ _____
Print Patient's full name *Signature of Patient/Responsible Party* *Date*

_____ _____
Patient's Date of Birth *Relationship to Patient*

_____ _____ _____
Patient's Social Security Number *Witness Signature* *Date*

NOTE: THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETED IN ITS ENTIRETY.
A COPY OF THIS FORM WILL BE ACCEPTED IN LIEU OF AN ORIGINAL.
A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PATIENT OR PATIENT REPRESENTATIVE

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:

We, the undersign, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

Verbal Consent requires signatures of two witnesses

_____ _____
Signature of witness *Date*

_____ _____
Signature of witness *Date*