Patient Label

Authorization for Release/Request of Protected Health Information Mount Nittany Health

MR#:________________________ Acct #:______________________

I hereby authorize **Mount Nittany Health,** consisting of Mount Nittany Medical Center (MNMC) and Mount Nittany Physician Group (MNPG), to release or request my health information:

Patient Information: Name: ____Date of Birth: ________________

Address: ____

Telephone: ______________________________ E-mail: ______________________________

Release Information To: Name:____

Address: : ____

Telephone: __________________________ Fax: _____________________E-mail: _______________________________

Request Information From: Name:____

Address: : ____

Telephone: __________________________ Fax: _____________________E-mail: _______________________________

The information to be released or requested shall be *limited* to the following:

Location of service (check all that apply): ☐ MNMC ☐ MNPG (specific office if needed):_________________________

Dates of service: ____

☐ Medical Record (complete)
☐ Consultation Reports
☐ Discharge Summary
☐ Safety Plan
☐ Pertinent MNMC (H&P, Consultation, Operative, Pathology, Diagnostic)
☐ Pertinent MNPG (Office notes, labs, procedures)
☐ ED Mental Health Evaluation & Liaison Note _____________________________________
☐ History and Physical (H&P)
☐ Laboratory Test Results
☐ Operative Reports
☐ Office notes
☐ X-Ray, Imaging Reports
☐ ED Records
☐ Discharge Instructions
☐ Progress Notes
☐ Medication List
☐ Other (specify):________________________

The purpose of the disclosure is as follows: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: ___________________

I authorize this information be released or requested in the following manner (check all that apply):

☐ Pick up ☐ Mail ☐ CD ☐ Fax: _______________________________________

☐ E-mail:____ ☐ Verbal – Behavioral Health Staff Only

I understand that this release may also include (Check to approve release of):

☐ Information relating to AIDS or HIV infection

☐ Information relating to mental health or psychiatric care continuing care plan and/or treatment for substance and/or alcohol abuse or dependency: excludes Psychotherapy notes

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

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NOTICE OF DISCLOSURE

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

Signature of Patient or Patient Representative | Print Name | Date | Time

Witness Signature | Date | Time | Witness Signature | Date | Time

If Patient is unable to give consent or if a Verbal consent is given, two MNH employees must sign as Witnesses.

If signed by Patient Representative, state relationship and authority to do so: (check all that apply)

- ☐ Parent of Minor
- ☐ Incompetent
- ☐ Disabled
- ☐ Deceased
- ☐ Custodial Parent
- ☐ Legal Guardian
- ☐ Executor of Estate of Deceased
- ☐ Authorized Legal Representative
- ☐ Power of Attorney for Health Care
- ☐ Other: ____

☐ Revoked_________________________________ ________________ ________________
Patient or Patient Representative | Date | Time

Office Use Only:

Photo ID Obtained: Y / N
Driver's License #:________________
Other:__________________________
Records Released on:_____________
Records Released by:_____________
Number of pages:_____________

Received by:______________________________Date:_______________Time:__________
Transmitted by:____________________________Date:_______________Time:__________

White – Medical Record

Form No. MR-055 Item #15047 Revised 2/4/15