Patient Label

MOUNT NITTANY HEALTH

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
☐ History and Physical (H&P)
☐ Laboratory Test Results
☐ Operative Reports
☐ Office notes
☐ X-Ray, Imaging Reports
☐ ED Records
☐ Discharge Instructions
☐ Progress Notes
☐ Pertinent MNMC (H&P, Consultation, Operative, Pathology, Diagnostic)
☐ Pertinent MNPG (Office notes, labs, procedures)
☐ ED Mental Health Evaluation & Liaison Note _____
☐ 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.

White – Medical Record

Patient Label

MOUNT NITTANY HEALTH

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

MR#:_____ Acct #:_____

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: ☐ / ☐
Driver's License #:_____
Other:_____
Records Released on:_____
Records Released by:_____
Number of pages:_____

Received by:_____Date:_____Time:_____
Transmitted by:_____Date:_____Time:_____

White – Medical Record