BROAD TOP AREA MEDICAL CENTER, INC.
4133 MEDICAL CENTER DRIVE, PO BOX 127
BROAD TOP, PA 16621 -9001
PHONE: 814-635-2916 FAX: 814-635-2918

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME: ____DOB:_________________

ADDRESS: ______________________________________ SS#: _____ - _____ - ______

____ PHONE#: ___________________________

EMAIL ADDRESS: _____________________________________

I HEREBY AUTHORIZE: ____

Name of Practitioner/Facility to Release Records

ADDRESS: ____

____

TO RELEASE TO:

____

Name of Practitioner/Facility to Receive Records

ADDRESS: ____

____

The extent or nature of information to be released is indicated below:

_____ INPATIENT CARE (DATES OF SERVICE) ____

_____ EMERGENCY CARE (DATES OF SERVICE) ____

_____ COMPLETE MEDICAL RECORDS _____ X-RAYS

_____ OFFICE NOTES (DATES) ________________________________ _____ LABORATORY

_____ DISCHARGE SUMMARY _____ MEDICATION LISTS

_____ OPERATIVE REPORT _____ HISTORY & PHYSICAL

_____ OTHER: ____

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The purpose for release of the above information is indicated below:

_____ CONTINUED CARE/TRANSFER _____ INSURANCE _____ LEGAL _____ OTHER

If other is checked, please specify reason needed:
____

I ____________________________________ GIVE CONSENT TO THE RELEASE OF THESE RECORDS, WHICH I UNDERSTAND MAY INCLUDE PSYCHIATRIC INFORMATION, DRUG AND ALCOHOL INFORMATION, AND/OR HIV INFORMATION.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the facility. This consent will expire in one year from the date signed, unless otherwise stated as follows: ____.
I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

X____ DATE SIGNED: _________________
SIGNATURE OF PATIENT

X____ WITNESS: _____________________
Signature of Parent, Guardian or Legal Representative

If signed by other than the patient, state relationship and reason for patient's inability to sign:

____

Verbal consent requires the signature of two witnesses:

____ ____

Signature of Witness DATE Signature of Witness DATE

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been _____ Accepted _____ Rejected by the Patient/Representative