Broad Top Area Medical Center, Inc
4133 Medical Center Drive, PO Box 127
Broad Top, PA 16621
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
- ☐ OFFICE NOTES (DATES) _____
- ☐ DISCHARGE SUMMARY
- ☐ OPERATIVE REPORT
- ☐ X-RAYS
- ☐ LABORATORY
- ☐ MEDICATION LISTS
- ☐ HISTORY & PHYSICAL
- ☐ OTHER _____

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:

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____ GIVE PERMISSION 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 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.