

Broad Top Area Medical Center, Inc. (BTAMC)

I authorize the use/disclosure of information as described below:

Name: _____ Date of Birth: ____/____/____
Last First Middle
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ - _____ - _____

I authorize BTAMC to: ☐ **Release My Records To:** **OR:** ☐ **Request My Records From:**

Name: _____ Phone: _____ - _____ - _____ Fax: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____

Information to Release or Request: **Date(s) of Service:** ____/____/____ to ____/____/____

☐ Complete Medical Record	☐ X-RAY/Imaging	☐ Laboratory	☐ Medication List
☐ Complete Dental Record	☐ Inpatient Care	☐ Operative Report	☐ Emergency Room
☐ Immunization Records	☐ Office Notes	☐ Inpatient Care	☐ Discharge Summary
☐ Drug/Alcohol Treatment Records	☐ HIV/AIDS	☐ Behavioral Health	☐ Other (Specify): _____

**I understand that my express consent is required below to release information regarding mental health, substance use disorder treatment, or HIV/AIDS-related information.*

Purpose of Disclosure/Release:

☐ Continued Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other (Specify): _____

I understand the following:

- I understand this consent is voluntary and that I may refuse to sign this authorization at any time. Refusing to sign this authorization will not affect my treatment, payment of my claim, health insurance enrollment, or eligibility for benefits. I understand that this authorization will expire in ninety (90) days or when the records are released for the requested data. Any requests after this date will need a separate authorization. I may take back (revoke) this authorization, in writing, and understand that some records may have been released before the authorization was withdrawn.
- I understand BTAMC will provide access to or copies of requested medical records **within thirty (30)** days of receiving a valid authorization, in accordance with applicable federal and state laws.
- I understand that once my records are released to individuals or entities other than healthcare providers, health plans, or government agencies/contractors, the information may be redisclosed by the recipient and will no longer be protected under federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).
- I can get a copy of this form after I sign it.
- I am entitled to receive my medical records in electronic format, if available.
- I understand that my records are protected under HIPAA, The Federal Privacy Act, The Federal Alcohol and Drug Abuse Act, the Pennsylvania Confidentiality of the HIV Related Information Act, and therefore cannot be disclosed without my written permission unless otherwise provided for in the regulations.

☐ **I give consent to the release of these records, which I understand may include Psychiatric Information, Drug and Alcohol Information, and/or HIV/AIDS Information.**

☐ I authorized the following person to pick up my records. **NOTE: Photo identification will be required to pick up records.**
 Name: _____ Pick up Date : ____/____/____

☐ If available, I request my records in electronic format
☐ Email (Address): _____

X _____ /____/____
 Signature of Patient or Legal Representative Authorized to Sign for Patient. Date

Printed Name of Patient or Legal Representative Authorized to Sign for Patient. Relationship if other than patient

X _____ /____/____
 Signature of Authorized Person to Pick Up Records Date

Broad Top Area Medical Center, Inc. Location Address's & Phone Numbers

Broad Top Medical Center

4133 Medical Center Drive, PO Box 127
Broad Top, PA 16621-9001
Phone: 814-635-2916
Fax: (814) 635-2918

Belleville Wellness Center

375 S. Kishacoquillas Street
Belleville, PA 17004-8620
Phone: 717-935-2065
Fax: 717-935-5560

Mount Union Medical Center

95 S. Park Street
Mount Union, PA 17066-1334
Phone: 814-542-8627
Fax: 814-542-5444

Juniata Valley BTAMC Clinic

846 Medical Center Drive, PO Box 355
Alexandria, PA 16611-2936
Telephone: 814-667-7400
Fax: 814-667-7395

Southern Huntingdon County Dental Clinic

626 Water Street, Suite 2, PO BOX 146
Orbisonia, PA 17243-9432
Phone: 814-447-3159
Fax: 814-447-3195

Trough Creek Medical Center

358 Seminary Street, PO Box 158
Cassville, PA 16623-6203
Phone: 814-448-9226
Fax: 814-448-2068

Huntingdon Family Care Center

835 Washington Street, PO Box 185
Huntingdon, PA 16652-1725
Phone: 814-506-8114
Fax: 814-506-8553 or 814-506-8623

Pediatric & Family Healthcare

6311 Margy Drive, Suite 2
Huntingdon, PA 16652-6934
Phone: 814-506-8490
Fax: 814-506-8493

Southern Huntingdon County Medical Center

626 Water Street, Suite 1, PO Box 40
Orbisonia, PA 17243-9432
Phone: 814-447-5556
Fax: 814-584-5741

Primary Care Center

790 Bryan Street, Suite 2
Huntingdon, PA 16652-2410
Phone: 814-907-3400
Fax: 814-907-3500

Family Wellness Center

419 14th Street
Huntingdon, PA 16652-1726
Phone: 814-643-3205
Fax: 814-643-6903

Walk-In Clinic

6678 Towne Center Blvd.
Huntingdon, PA 16652-6934
Phone: 814-643-1232
Fax: 814-643-4267