Broad Top Health & Wellness
BTAMC Inc.

Broad Top Area Medical Center
4133 Medical Center Drive, PO Box 127
Broad Top, PA 16621-9001
Telephone: 814-635-2916
Fax: 814-635-2918 or 814-635-7865

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 (1) Date Signature of Witness (2) 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.