

LENDALE AREA MEDICAL CENTER
850 Main Street
PO Box 375
Coalport, PA 16627
(814) 672-5141
Fax (814) 672-5461

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME _____ **BIRTHDATE:** _____

ADDRESS: _____ **SS#:** _____

I hereby authorize _____ to release to

(Complete name and address)

the following medical records, which I understand may include psychiatric information, drug and alcohol information, and/or HIV information.

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

- | | |
|--|---|
| <input type="checkbox"/> Complete medical record | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Medication sheets |
| <input type="checkbox"/> Admission/Discharge summary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Operative reports | _____ |
| <input type="checkbox"/> Emergency Room reports | _____ |
| <input type="checkbox"/> X-Rays | _____ |

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

- Continued care Insurance Legal Other _____
(Specify)

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 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.

Signature of patient

Date signed

Signature of parent, guardian or legal representative

Witness

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

Verbal consent requires 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.