Penn Highlands Mon Valley

1163 Country Club Road, Monongahela, PA 15063-1095

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ M.R. # _____

Address _____ Birth Date _____

City _____ State _____ Zip _____ Phone # _____

I Authorize Penn Highlands Mon Valley to: Obtain/Release

Information from/to: _____

Address: _____

Information to be released: _____ FS _____ DRG _____ H&P _____ CON _____ OR _____ DS _____ XRAY

_____ PATH _____ ER _____ LAB _____ EKG _____ ENTIRE _____ OTHER _____

Service/Dates: _____ INPT _____ OPD _____ ER _____ OPS _____

Purpose for the release: _____

I understand that the hospital will not condition treatmcnt, payment, enrollment or eligibility for benefits on whether or not I sign this form. I understand that I may revoke this consent in writing, or verbally if unable to sign, at any time except to the extent that action based on this consent has already been taken. I also understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. This authorization is for full release of all records, subject to any restrictions noted above, including clinical findings, diagnoses, treatment, assessment, recommendations for further care, dates of hospitalization and ambulatory visits and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases including HIV testing and other AIDS related testing information.

_____ _____
Signature of Patient or Representative — Date

_____ _____
Witness — Date

_____ _____
*Witness — Date

This authorization is valid for 90 days starting on _____ and ending on _____
*A second witness is required when a verbal authorization is taken from a patient who is unable to sign.

Records given to patient _____ Paid _____

FORM POD-165100 REV. 1/22

AUTHFORRELEASE