



Authorization to Use and Disclose Protected Health Information

1850 East Park Avenue, State College, PA 16803
3901 S. Atherton Street, State College, PA 16801
141 Medical Park Lane, Bellefonte, PA 16823

Department of Medicine (814-234-8800)
Department of Pediatrics (814-466-7921)
Department of Medicine (814-355-7322)

Department of OB/GYN (814-237-3470)
Department of Surgery (814-466-2300)
Department of Pediatrics (814-355-3626)

Patient's Name _____ Date of Birth _____ Soc. Sec.# _____

Telephone Number _____ When needed, date _____ time _____

I authorize _____ to release copies of medical records and/or other protected health information to Centre Medical and Surgical Associates, P.C. for the purpose of _____.

Records will be: Picked up Mailed to the address above

The following information is protected by law. Please <u>initial</u> if you agree to its release.		
Yes	No	
_____	_____	HIV or AIDS related information
_____	_____	Alcohol or Drug Abuse Records
_____	_____	Mental Health Information
_____	_____	Records of sexual abuse counselors

Information requested (please check all that apply):

- Physician Progress Notes
- Laboratory Results
- Procedure Records
- Other _____

Dates requested:

- Past 12 months
- Past 5 years
- All date of service (per page copying fees still apply)
- Other _____

This authorization will be valid for one year from the date it was signed.

This consent may be revoked at any time except to the extent action has been taken in reliance upon it by sending a written statement specifying the date this authorization was signed to the releasing provider's Privacy Official. The statement must include the date on which this authorization is no longer in force. If this authorization is to permit the releasing provider to disclose information to an insurance company in order for you to obtain coverage, the insurance company may still have the legal right to use the information to contest a claim or your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from the releasing provider unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

A person or organization that receives your information because of this authorization may disclose this information to other people or organizations without your knowledge or consent.

I fully understand the nature of this authorization and the charges that will be incurred.

Patient/Legal Representative Signature: _____ Date: _____

Witness/Staff Person's Signature: _____ Date: _____

Oral Consent (Only for persons physically unable to sign, whose records are being released pursuant to the Pennsylvania Mental Health Procedures Act.)

I witness that _____ (patient's name) understood the nature of this release, understood that he/she may orally revoke this consent at any time except to the extent that action has been taken in reliance upon it and freely gave his/her oral consent.

Witness 1 _____ Date _____ Witness 2 _____ Date _____