
Initials and Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:

Address

Address::

Birthdate:

(Name of releasing doctor, hospital, insurance company or other agency or person)

Address of releasing party

Telephone Number

I authorize an appropriate workforce member of the above entity to release information from my medical record to:

Pleasant Valley Family Medicine

(Name of doctor, hospital, insurance company or other agency or person to whom the information will be released)

208 E Church Street Suite 100 Lock Haven, PA 17745

570-748-7400

info@pvmed.com

Address of receiving party

Telephone Number

FOR THE PURPOSE OF:

- continuation of medial treatment
- payment of bill
- At the request of the patient or the patient's legal representative for the personal access or other (specify):
- Worker's Compensation
- Education
- Legal purposes
- Insurance purposes

The information will cover the time period from _____ to _____

This Authorization will expire on or upon (insert date or event) _____.

If not specified, this Authorization will expire six (6) months from the date on which it was signed.

SPECIFIC INFORMATION TO RELEASE:

- Discharge Summary
- Catheterization Report
- Pathology Reports
- Other (specify)
- Other (specify)
- Other (specify)
- Other (specify)
- History & Physical
- Clinic Notes
- X-ray Reports
- Consultation Report(s)
- Emerg Room Notes
- X-ray Films
- Operation Report(s)
- Laboratory Reports
- Itemized Bills

SPECIAL AUTHORIZATION: The following items must be initialed to be included in the use of disclosure of protected health information pursuant to this authorization form:

- HIV/AIDS related health information and/or records
- Mental health information and/or records
- Genetic testing information and/or records
- Drug/alcohol diagnosis, treatment, and or referral information

Pennsylvania law restricts the purposes for which disclosures may be made. Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Reception Office Staff. I understand that the revocation will not apply to information that already has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may no longer be protected by Pennsylvania or federal privacy law, and the person or organization that receives this information may have the legal right to disclosed the information to other people or organizations without my knowledge or consent.

I understand that I may refuse to sign this Authorization and that I need not sign this form to receive healthcare treatment from my current provider. I understand there could be a fee for record copies.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIATED MINOR, THE PARENT OR GUARDIAN MUST SIGN.

Date: _____ Patient Signature: _____

Date: _____ Witness Signature: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign authorization form because:

Date: _____ Signature: _____ Relationship: _____

Date: _____ Witness Signature: _____