PATIENT'S NAME *(Please Print)* ______________________ DATE OF BIRTH ______________

ADDRESS *(Street, City, State)* ______________________ PHONE *(Area Code and Number)* (   ) ______________

I, the undersigned authorize **Abington Memorial Hospital (AMH)** the use/disclosure of health information pertaining to the patient named above.

I further authorize the use/disclosure of the above named patient's health information to the following person(s) and/or entity:

From: ______________________ To: ______________________
PLEASE PRINT NAME OF INDIVIDUAL OR ENTITY

______________________ ______________________
ADDRESS (Street Name and Number)

______________________ ______________________
ADDRESS (City, State and Zip Code)

I request that only the following health information be used or disclosed by AMH:
Please describe the health information for the above named patient to be used or disclosed (eg. Medical Records, etc.)

____

____

I request the use and/or disclosure of the above named patient's health information for the following purposes: *If patient is requestor please write "at the request of the patient")*

____

____

I understand that if the person or entity that receives my health 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 those regulations. (Please see federal and state law prohibitions on redisclosure on reverse side of this form)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written request to the AMH Patient Relations Department except to the extent that action has been taken in reliance on this authorization.

This authorization is valid - From: ______________ to: ______________
PLEASE FILL IN DATE PLEASE FILL IN DATE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLACE PATIENT LABEL HERE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize AMH to use or disclose the health information noted on the reverse side, including any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition(s), including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information; (In accordance with Federal confidentiality rules (42 CFR Part 2), State Mental Health Procedures Act and Act 148).

If there are any limitations to this list of health information to be used and/or disclosed please specify:

____

____

NOTICE TO RECIPIENT OF PATIENT HEALTH INFORMATION:
Certain health information including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information are subject to confidentiality rules under state law and Federal confidentiality rules (42CFR Part 2). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Confidentiality of HIV-Related Information Act and State law. Federal rules prohibit the use of health information use/disclosed with this authorization to criminally investigate or prosecute any alcohol or drug abuse patient.

Please note all sections of this form must be completed for this authorization to be valid.

SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE __________ DATE __________

NAME OF PERSONAL REPRESENTATIVE __________ RELATIONSHIP TO PATIENT __________

If the Patient and/or Personal Representative is unable to sign please state the reason below and have two witnesses who can attest to the fact that the patient and/or Personal Representative understand the nature of this release and freely give his or her consent.

REASON PATIENT AND/OR PERSONAL REPRESENTATIVE IS UNABLE TO SIGN __________

WITNESS SIGNATURE __________ WITNESS NAME *(Please Print)* __________

WITNESS SIGNATURE __________ WITNESS NAME *(Please Print)* __________

DATE __________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLACE PATIENT LABEL HERE