GUTHRIE
Towanda Memorial Hospital

91 Hospital Drive, Towanda, PA 18848
570-265-2191

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	MR #	Birth Date	Social Security No.
Address	Telephone No. ( )		

I hereby authorize____
Facility Name

ALL MEDICAL INFORMATION FORWARDED MUST INCLUDE – FIRST NAME, LAST NAME, AND DATE OF BIRTH. IF NOT INCLUDED INFORMATION IS UNACCEPTABLE

To release information from the medical records of________________________________
Patient Name

To:____
Name/Address of person/organization to which disclosure is to be made
____

For the following purpose:____

For treatment date(s):____
Specify dates – this line MUST BE completed

Type of Access Requested	Select Portions		
❑ Copies of the record	❑ Abstract/Pertinent Information	❑ Lab	❑ MD Progress Notes
❑ Inspection of the record	❑ Emergency Room	❑ Imaging/Radiology	❑ MD Orders
❑ Access to CDR	❑ H & P	❑ Cardiac Studies	❑ Entire Record
	❑ Consultation	❑ Face Sheet	❑ Other________________
	❑ Operative/Procedure report	❑ Nursing Notes	______________________ ______________________

This authorization expires 60 days from the date signed below and covers only treatment for dates specified above.

__________ **I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug**
Initials **abuse, psychiatric, HIV results, or AIDS information.**

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this “Authorization for Release of Medical Information”. I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization. I understand federal and state laws permit a fee to be charged for copying of patient records.

________________ ____ ________________________________
Date Signature of Patient/Parent/Conservator/Guardian Relationship to Patient/Authority to act for patient

________________________________ ________________________________
ID Presented Verified By

THIS AUTHORIZATION WILL NOT BE VALID UNLESS ENTIRELY FILLED OUT

Notice to the Recipient: The recipient of the enclosed information is not authorized to use this patient’s Medical Records information for any purpose other than for that stated above or to disclose any information to any other person or facility without specific written authorization for the patient to do so.

A copy of this completed, signed and dated form must be given to the Individual or other Authorized Representative upon request.

FORM # 0571him-9 Approved by HIPAA Committee 03/26/03, REV.01/26/10