Summit Health
THE PEAK OF GOOD HEALTH

Medical Record # _____
☐ **Mail Out Date:_____**
☐ **Pick-up Date:_____**

MR.AFROI

AUTHORIZATION FOR RELEASE OF INFORMATION

Entity: Please check the appropriate box and provide a copy of this form to the patient.

☐ Chambersburg Hospital
112 North Seventh St.
Chambersburg, PA 17201
(717) 267-7158
Attention: HIM Dept.

☐ Waynesboro Hospital
501 East Main St.
Waynesboro, PA 17268
(717) 765-3412
Attention: HIM Dept.

☐ Summit Surgery Center
757 Norland Ave.
Chambersburg, PA 17201
(717) 217-6720

☐ Summit Cancer Treatment Center
_____
_____
_____

☐ SPS (Practice Name/Address)
_____
_____
_____

☐ Outpatient Behavioral Health
176 S. Coldbrook Ave.
Chambersburg, PA 17201
(717) 267-7480

Patient Reference:

Patient's Name:_____Birth Date:_____
Address:_____
Name at Time of Admission Other Than Above:_____
Phone # _____
Medical Record Number: _____
Account Number(s): _____

Information to be Released To:

Specify Name and Address:
_____
_____
_____

Verified ID:
☐ Yes
☐ No

☐ I am requesting a copy of my own health information Date:_____Time:_____
☐ I am requesting to review my own health information. Date:_____Time:_____

Name of Other Facility Disclosing Information to Summit Health:

_____
_____
_____

Records Involved: **Dates:**

__Inpatient Admission _____
__Emergency Room _____
__Outpatient Service _____
__Other _____

Nature and Extent of Information to be Disclosed: (*Please check and circle all that apply)*

__Adm./Disch.-Final Diagnosis __ER/OP Record __X-rays, EKGs, EEG's, Echo, Pathology
__Discharge Summary __Postmortem/Autopsy __Lab Reports, PFT, Stress Test, Holter Monitor
__History/Physical Exam __Operative Report __Consultation Report
__Progress Notes/Doctor's Orders __Initial Assessment __Discharge Instructions
__ Entire copy of Medical Records __ Therapy Notes- Physical, Occupational & Speech
__Abstract: (History & Physical, Discharge Summary, ER Report, Consult Report, Lab Results, Operative Report, Pathology Report, X-ray Results)
__Radiology Images:_____
__Other - Specify:_____
☐ I acknowledge receipt of original radiology images and I understand that these images are the property of the facility named above. I agree to return these images to the facility named above.

Please Note: All patients should consult their physician for information regarding the interpretation of their test results.

SEE OTHER SIDE

Purpose of Disclosure: _____Legal ____Insurance _____ Social Security Disability
_____Other - Specify:_____
_____Continued Treatment: (Please provide:)
Name & Address:_____
_____
_____
_____

Effective Date of Authorization: _____ Expiration Date of Authorization:_____
Please note: Behavioral Health Inpatients have a 60-day expiration on authorizations.

SPECIAL AUTHORIZATION: I understand that my medical records may contain alcohol/drug abuse, Human Immune Virus/Acquired Immune Deficiency Syndrome related and/or mental health information. I give special authorization to the health care facility to release this information in my records to the person or organization named above, for reasons outside of continuity of care.

_____ Patient Initials

GENERAL AUTHORIZATION: I understand and acknowledge that this authorization allows the entity outlined above to release all or part of the records indicated above with the exception of the specially protected health information referred to under the Special Authorization section of this form. I understand that, **on occasion,** general information may be released by telephone or fax.

(1) I understand that I may revoke this Authorization at any time, except to the extent that action based on this Authorization has been taken, by sending a letter signed by me to: Privacy Officer, Summit Health, 112 North Seventh Street, Chambersburg, PA.
(2) The entity outlined above may not condition treatment on my agreement to sign this Authorization.
(3) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipients listed above and may no longer be protected.
(4) This Authorization is fully understood by me and is made voluntary on my part.

Date Signed:_____ Patient's Signature:_____

Time Signed:_____

_____ _____
Signature of Witness Required Signature of Parent/Guardian or Legal Representative (if signed by other than patient, state relationship and reason for patient's inability to sign)
Relationship: _____
Reason for patient's inability to sign: _____

The following is to be used for verbal consent by a person physically unable to provide a signature (excluding Drug and Alcohol related to treatment program at Chambersburg Hospital, Mental Health, and HIV-related information):

This form has been read and explained to me, I fully understand its contents, and I verbally authorize the release of information describe above.
Date Signed: _____

Time Signed:_____

Witness #1 Printed Name: _____ Witness #2 Printed Name: _____

Witness #1 Signature: _____ Witness #2 Signature: _____