LEWISTOWN HOSPITAL

Lewistown Healthcare Foundation; Family Health Associates; Health Enterprises, Inc.
Lewistown Ambulatory Care Corp.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:_____

Medical Record Number:_____

Date of Birth:_____

I authorize the use or disclosure of the above named individual's health information by Medical Staff or other agents of: (Name of Organization)

_____

_____

To use or disclose the following health information about me for the purpose of:_____

_____

Hospitalization and/or treatment dates:_____

Type of visit: (please check all that apply): ❑ Inpatient ❑ Outpatient ❑ ED

Copies Needed: (please check all that apply): ❑ Imaging Reports ❑ Imaging Films ❑ Entire Copy of Medical Record
❑ Discharge Summary ❑ H&P
❑ Other, Please specify:_____

The health information described above may be used or released to:

_____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I read this form or had it read to me and I understand.

This authorization is valid starting (date):_____ ending:_____(expiration date)

Signature of Patient:_____ Date:_____

Relationship if signed by other than patient:_____

Witness:_____

Patient is unable to sign his or her name. I attest that he/she has verbally authorized the use of disclosure indicated on this form.

Witness:_____

Witness:_____

LEWISTOWN HOSPITAL

Lewistown Healthcare Foundation; Family Health Associates; Health Enterprises, Inc.
Lewistown Ambulatory Care Corp.

AUTHORIZATION FOR THE USE OR DISCLOSE HEALTH

By signing this Authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this Authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform this test if you refuse to sign the Authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form.**

Consequences of Signing this Form

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or Organization to whom your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others. Pennsylvania law protects HIV-related information and mental health records from re-disclosure, except as other wise permitted by State Law.

Revocation

You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may have the right to revoke the Authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to:

Ron Cowan, Privacy Officer
Lewistown Hospital
400 Highland Avenue, Lewistown, PA 17044

If Authorization was given verbally, this authorization may be revoked verbally by contacting Ron Cowan, Privacy Officer at (717) 242-7218. You will need two witnesses to witness a written attestation of verbal revocation and forward to Privacy Officer at Lewistown Hospital.

Expiration

Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.