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HERITAGE VALLEY
Health System

FM 415

STAUNTON CLINIC
AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. **Failure to provide all information requested may invalidate this authorization.**

Patient Name: **Date of Birth:**

Address: **Telephone #:**

Date(s) of treatment: (Note: authorization is not valid *prior* to care being rendered.)

From date:_____ To date:_____

The specific information to be disclosed from my medical/treatment records includes:

_____

_____

Purpose of Disclosure:_____

Individual(s) or organization(s) authorized to use or disclose the information:

r Staunton Clinic Edgeworth Square 111 Hazel Lane, Suite 300 Sewickley, PA 15143

r Other:_____

Individual(s) or organization(s) authorized to receive the information:

Name:_____

Address:_____

Telephone:_____

PATIENT RIGHTS:

I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed it may not be under the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Medical Records Department or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

I understand that my medical record may contain sensitive information relating **to AIDS, HIV, psychiatric care, and or treatment for drug and/or alcohol use. I give consent** for use and disclosure of this type of information: (Please list exclusions, if any)

_____

_____ _____

Signature of Patient Date

OR

_____ _____

Signature of Patient's Legal Representative Date

_____ _____

Print Name Relation to Patient

_____ _____

Signature of Witness Date

EXPIRATION: This authorization is valid for six months from the date of signature, unless the authorization is revoked by written notice.