Abington Memorial Hospital

1200 Old York Road, Abington, PA 19001

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

_____ ___/___/_____
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:
Abington Memorial Hospital Please Print Name of Individual or Entity	_____ Please Print Name of Individual or Entity
1200 Old York Road Address (Street Name and Number)	_____ Address (Street Name and Number)
Abington, PA 19001 Address (City, State and Zip Code)	___ ____ Address (City, State and Zip Code)

I ASK THAT ONLY THE FOLLOWING HEALTH INFORMATION BE USED OR DISCLOSED BY AMH

RADIOLOGY RECORDS: list studies by name & date/ accession #----------
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

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize AMH to use or disclose the health information noted above 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 42). 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

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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 to the fact that the patient and/or Personal Representative understand the nature of this release and freely gave his or her consent.

_____ _____
Reason patient and/or Personal Representative is unable to sign Witness Signature

___/____/_____ _____
Date Witness Name (Please Print)

_____
Witness Signature

_____
Witness Name (Please Print)

_____acknowledge accuracy of the patient and record identification
name