

Authorization for Release of Protected Health Information

I authorize the following facility(s):

- WellSpan Newberry Hospital
- WellSpan Shrewsbury Hospital
- WellSpan Carlisle Hospital

to release information from the record of:

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip code

Patient Phone Number: _____

as described below, the information will be released to:

Facility/Person to Receive Records _____

Phone: _____ Fax/Email: _____

Address: _____
Street City State Zip code

I have been a patient at your facility or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

Place a check by types of records desired:

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire Clinical Record | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Physician Progress Reports |
| <input type="checkbox"/> Laboratory Reports/Tests | <input type="checkbox"/> Psychiatric/Psychological Evaluation | |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Radiology Report | |
| <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Pathology Report | |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Abstract (<i>history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports</i>) | |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing or other business records (<i>specify</i>): _____ | |
| <input type="checkbox"/> Other (<i>specify</i>): _____ | | |

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

- | | | |
|---------------------------------------|------------------------------|--|
| <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> HIV | <input type="checkbox"/> Mental Health (Psychiatric) |
|---------------------------------------|------------------------------|--|

Reason for Request:

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Continuing treatment | <input type="checkbox"/> Employer | <input type="checkbox"/> Insurance | <input type="checkbox"/> Study/Research |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Disability | <input type="checkbox"/> I do not wish to disclose the reason | |
| <input type="checkbox"/> Other: _____ | | | |

Dates of Service for record requests: _____

This authorization will expire in six months or: _____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

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I understand that this authorization is subject to revocation at any time, except to the extent that the facility has already taken action in reliance upon it or to the extent previously disclosed within the HIPAA NOTICE OF PRIVACY PRACTICES for Treatment, Payment, and/or Business Operations. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and deliver to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive, and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature _____ Date _____ Time _____

If representative, give relationship and authority to act _____

****If authority to act is a Power of Attorney, supporting documentation must be included with this request.****

Identity of requestor verified via _____ Photo ID _____ Matching Signature _____ Other, Specify _____

Witness Signature _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

All release of information requests must be sent directly to the corresponding facility. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

WellSpan Newberry Hospital

Attn: Medical Records Dept.
36 Robinhood Dr.
Etters, PA 17319
Phone: 717-388-7300
Fax: 717-388-7326

WellSpan Shrewsbury Hospital

Attn: Medical Records Dept.
14781 Wolfe Rd.
New Freedom, PA 17349
Phone: 717-326-1880
Fax: 717-326-1885

WellSpan Carlisle Hospital

Attn: Medical Records Dept.
1201 Letort Springs Way
Carlisle, PA 17015
Phone: 717-674-7600
Fax: 717-674-7626