

Patient Label



**Authorization for Release/Request
of Protected Health Information
Mount Nittany Health
Page 1 of 2**

MR#: _____ Acct #: _____

I hereby authorize **Mount Nittany Health**, consisting of Mount Nittany Medical Center (MNMN) and Mount Nittany Physician Group (MNPNG), to release or request my health information:

Patient Information: Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ E-mail: _____

Release Information To: Name: _____

Address: _____

Telephone: _____ Fax: _____ E-mail: _____

Request Information From: Name: _____

Address: _____

Telephone: _____ Fax: _____ E-mail: _____

The information to be released or requested shall be limited to the following:

Location of service (check all that apply): ☐ MNMC ☐ MNPNG (specific office if needed): _____

Dates of service: _____

- | | | |
|---|---|---|
| ☐ Medical Record (complete) | ☐ History and Physical (H&P) | ☐ X-Ray, Imaging Reports |
| ☐ Consultation Reports | ☐ Laboratory Test Results | ☐ ED Records |
| ☐ Discharge Summary | ☐ Operative Reports | ☐ Discharge Instructions |
| ☐ Safety Plan | ☐ Office notes | ☐ Progress Notes |
| ☐ Pertinent MNMC (H&P, Consultation, Operative, Pathology, Diagnostic) | ☐ Medication List | ☐ Other (specify): _____ |
| ☐ Pertinent MNPNG (Office notes, labs, procedures) | | |
| ☐ ED Mental Health Evaluation & Liaison Note | | |

The purpose of the disclosure is as follows: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

I authorize this information be released or requested in the following manner (check all that apply):

- ☐ Pick up ☐ Mail ☐ CD ☐ Fax: _____
- ☐ E-mail: _____ ☐ Verbal – Behavioral Health Staff Only

I understand that this release may also include (Check to approve release of):

- ☐ Information relating to AIDS or HIV infection
- ☐ Information relating to mental health or psychiatric care continuing care plan and/or treatment for substance and/or alcohol abuse or dependency: excludes Psychotherapy notes

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

White – Medical Record



Form No. MR-055 Item #15047 Reviewed 3/1/18

Patient Label



**Authorization for Release/Request
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Page 2 of 2**

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NOTICE OF DISCLOSURE

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

_____ Signature of Patient or Patient Representative	_____ Print Name	_____ Date	_____ Time
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_____ Witness Signature	_____ Date	_____ Time	_____ Witness Signature	_____ Date	_____ Time
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If Patient is unable to give consent or if a Verbal consent is given, two MNH employees must sign as Witnesses.

If signed by Patient Representative, state relationship and authority to do so: (check all that apply)

- | | | | | |
|--|---|--|-----------------------------------|---|
| ☐ Parent of Minor | ☐ Incompetent | ☐ Disabled | ☐ Deceased | ☐ Custodial Parent |
| ☐ Legal Guardian | ☐ Executor of Estate of Deceased | ☐ Authorized Legal Representative | | |
| ☐ Power of Attorney for Health Care | ☐ Other: _____ | | | |

☐ Revoked _____	_____ Date	_____ Time
Patient or Patient Representative		

Office Use Only:

Photo ID Obtained: Y / N

Driver's License #: _____

Other: _____

Records Released on: _____

Records Released by: _____

Number of pages: _____

Received by: _____ Date: _____ Time: _____

Transmitted by: _____ Date: _____ Time: _____

White – Medical Record



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