

Altoona Arthritis & Osteoporosis Center

Altoona Center for Clinical Research

Authorization For Release of Health Information

I hereby authorize: Name of Facility/Person _____

To release information from the record of:

Patient Name _____

Date of Birth _____

SSN/MR# _____

As described below to:

Name of Facility/Person _____

Street Address _____

City, State, Zip _____

Phone _____ Fax _____

Records are requested for the purpose of (provide a detailed description):

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):

___ Inpatient dates: _____ ___ Emergency Department: _____

___ Outpatient dates: _____ ___ Physician Office dates: _____

2. Specific information to be released (check all that apply):

___ Consultation Reports

___ Med. History/Physical Exam

___ Physician Orders

___ Discharge Summary

___ Medication Records

___ Progress Notes

___ Lab Reports/Tests

___ Operative Reports

___ Psychiatric Eval.

___ Mammography Report

___ Pathology Report

___ X-ray Reports

___ Emergency Dept. Report

___ EKG Report(s)

___ Discharge Instructions

___ Other, please specify: _____

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.

PLEASE DO NOT RELEASE ___ HIV ___ MENTAL HEALTH ___ DRUG & ALCOHOL

(continued on back—please complete both sides)

I understand that I have the following rights:

Right to disclose. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule.

Right not to sign. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Altoona Arthritis & Osteoporosis Center, Altoona Center for Clinical Research or the Altoona Specialty Center except when services are for the purpose of reporting a third party, i.e. employment physical.

Right to revoke. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person.

I understand that this Authorization is effective for a period of 1 year from the date of signature, unless otherwise specified below. No time frame may exceed 1 year from date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person. I authorize above to release the information. If applicable, specify other expiration date/event here:

Date_____Signature of Patient_____

Date_____Signature of Parent/Legal Guardian/Authorized Person*_____

*Authorized Person's relationship and authority to act on behalf of patient_____

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT applicable to HIV related information or drug & alcohol information.

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required.)

Date_____Witness #1_____

Date_____Witness #2_____

Please return completed form to:

Altoona Arthritis & Osteoporosis Center/Altoona Center for Clinical Research

175 Meadowbrook Lane

P.O. Box 909

Duncansville PA 16635

Phone: (814) 693-0300 Fax: (814) 693-0400