GRAND VIEW HEALTH

P.O. Box 902
700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4850

AUTHORIZATION: RELEASE/DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Medical record confidentiality is protected by the Federal Privacy Act (PL 93-282) and the PA Mental Health Procedures Act. Federal and State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

Consequences of Signing this Form

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or organization to whom your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

Revoking Authorization

You may revoke this Authorization, in writing, at any time except to the extent that action has already been taken in reliance to this Authorization. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to:

Privacy Officer
Grand View Health
700 Lawn Avenue
Sellersville PA 18960

Expiration of Authorization

Unless otherwise revoked, this Authorization will expire at the end of the calendar year in which it was signed.
Once this Authorization has expired, we will no longer disclose or use your health information for the purpose listed in this Authorization unless you sign a new Authorization form.

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PATIENT AUTHORIZATION

I hereby authorize _____
Name of Facility and Address
to disclose the following information from the health records of:

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Email address _____ Telephone No. ( ) -

Date(s) of service _____

Information to be disclosed: * Included in Abstract

- ☐ Abstract*
- ☐ Consultation Report*
- ☐ Discharge Summary*
- ☐ EKG, EEG, Stress, ECHO*
- ☐ Emergency Dept Records
- ☐ History & Physical*
- ☐ Immunizations
- ☐ Laboratory Results*
- ☐ Operative Report*
- ☐ Pathology Reports*
- ☐ Progress Notes
- ☐ Imaging Reports*
- ☐ Imaging Films (X-rays, Scans, etc)
- ☐ Other (please specify) _____
- ☐ Physician's Office Records (available only at the physician's office)
- ☐ Pediatric Office notes
- ☐ Growth chart
- ☐ Urgent Care

I understand that this will include information relating to (check if applicable);

- ☐ Behavioral Health services / psychiatric care.
- ☐ Sexually transmitted disease.
- ☐ Treatment for alcohol, drug, or general abuse.
- ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.

☐ **Exception: I do not give permission to release (please specify):** _____

This information is to be disclosed to:

_____
Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self

Address: _____ Fax #: ( ) -
(Healthcare organization only)

For the Purpose of: ☐ Personal Access ☐ Social Security/Disability ☐ Legal Purposes ☐ Continuation of Care ☐ Insurance Purposes ☐ Other: _____

Medium of delivery: ☐ Hard copy ☐ CD ☐ Electronic download via email (pt request only) ☐ Electronic Upload (Third party or vendor only)

COPY CHARGES MAY APPLY

- V Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.
- V I understand that Grand View Health may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- V I also understand that this consent may be revoked by me at any time by submitting a written revocation notice.
- V I understand that if this form is submitted electronically to GVH, there is no guarantee of secure transmission until it is received by GVH.

I understand that my authorization will remain effective until the end of the calendar year.

Patient's Signature _____ Date _____

The above individual is unable to consent/sign because (check one):

☐ Minor If minor, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
If yes, Legal documentation provided? ☐ Yes ☐ No
☐ Incompetent
☐ Other (explain): _____

_____ _____ _____
Authorized Representative Signature Date Relationship

For office use only:

ID Confirmed: ☐ Yes ☐ No

MRN# _____ Encounter # _____ Released By: _____

☐ Patient Identification
☐ Photo ID
☐ POA Provided

Given to: _____ Date & Time _____

☐ Emergency ☐ Refused due to: _____

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