

Underground Archives Authorization

Authorization to Use or Disclose Protected Health Information (PHI)

I hereby authorize _____ to release information from the records of:

Name of Patient : _____ : _____
Date of Birth : _____
Last four Digits of SSN.

This information is to be released to:

T: _____
F: _____

Records are being requested for the purpose of: _____

Types of records to be released and approximate dates of service (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Inpatient; Dates: _____ | <input type="checkbox"/> Emergency; Dates: _____ |
| <input type="checkbox"/> Outpatient; Dates: _____ | <input type="checkbox"/> Physician Office; Dates: _____ |
| <input type="checkbox"/> ENTIRE MEDICAL RECORD (Includes all sections mentioned below.) | |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Medical History/Physical Exam |
| <input type="checkbox"/> Care Plans | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Clinician office notes | <input type="checkbox"/> Multidisciplinary Progress Notes |
| <input type="checkbox"/> Consultant Reports | <input type="checkbox"/> Operative/Recovery/Anesthesia |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Emergency/Urgent Care Records | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Labor and Delivery Records | <input type="checkbox"/> Psychiatric Evaluations |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> Mammography Report | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Other _____ | |

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:

_____ HIV _____ Mental Health (Psychiatric) _____ Drug & Alcohol

This authorization will expire in 1 Year unless I otherwise indicate here: _____

My signature below indicates that: I have read and understood this information. I have received a copy of this form. I am the patient, and/or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms. Please see below for additional patient rights and responsibilities.

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

Representative's Signature: _____ Relationship to Patient: _____

Representative's Printed Name: _____ Date: _____

Patients Must Understand the Following:

Treatment cannot be withheld if the patient refuses to sign the Authorization. The law requires that a disclosure statement will accompany all records released. This form dictates what records will be released, and for what purpose; no items will be released if they have not been listed or otherwise indicated on this form. Underground Archives is neither liable nor responsible for any re-disclosure of records once they are received by the organization/person/facility that makes the request. A patient may revoke this authorization at any time by sending a written request to the entity authorized to release the information. A patient's decision to revoke the Authorization is not retroactive; it does not apply to any release of his or her records which may have taken place prior to the date of the revocation of the Authorization. The decision to revoke the Authorization may result in the patient's insurance company's not being able to authorize payment for medical care: It must be understood that the patient may be responsible for payments of any and all claims filed. In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation, or parole officers, insurance company, health or hospital plan, or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse. The patient is entitled to a copy of his or her completed Authorization form. A faxed copy of this authorization shall serve in lieu of the original.