PATIENT AUTHORIZATION FORM

Section A: This section must be completed for all Authorizations		
Patient Last Name	**First Name**	**MI**
Date of Birth	**Social Security Number (*optional):***	
Name and address of health provider or entity to release this information:		
My health information may be released to (name of recipient):		
Address 1:		
Address 2:		
City:	**State:**	**Zip:**
Phone Number:	**Email Address:**	
Fax Number:		

The purpose of requesting release of this health information is: _____
_____

I hereby authorize the use or disclosure of protected health information as described below:
Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All PHI in medical record (note exceptions in sensitive information section) ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests		☐ Discharge Summary ☐ Progress Notes ☐ Initial Evaluation ☐ Itemized bill ☐ History and Physical exam ☐ Radiology Reports		☐ Other: ☐ Other: ☐ Other:	

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficient Syndrome (AIDS).
If you would like any of the following sensitive information disclosed, initial the applicable line(s) below:
___Alcohol / Drug Abuse Treatment / Referral ___ HIV/AIDS-related Testing and/or Treatment
___Sexually Transmitted Diseases ___ Mental Health (Other than Psychotherapy notes)
___Genetic Testing – provide purpose of disclosure and to whom disclosed _____
_____
Please describe below the exact nature and dates of medical records that you would like to release (e.g., laboratory tests and results taken between January 1, 2007 and March 31, 2007). _____

Preferred method of delivery: ☐ secure email ☐ mail ☐ pick up of paper copies ☐ fax ☐ patient portal (where available)

I understand that:

1. If the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by the federal privacy regulations and may be re-disclosed.
2. I may revoke this authorization in writing at any time by sending a written revocation to: Select Medical Corporation, Attn: Privacy Officer, 4714 Gettysburg Road, P.O. Box 2034, Mechanicsburg, PA 17055. I understand that my revocation is not effective to the extent that action has been taken by Select Medical Corporation in reliance on this authorization. However, I understand that if my participation in a mental health program is a condition for my release from confinement, probation, or parole, then I may not revoke this authorization.
3. I am not required to sign this authorization form and that Select Medical Corporation will not withhold the provision of treatment or payment to me as a condition of the signing of this authorization.
4. This Authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line. In the event the health information described above includes any of these types of information, and I initial the line, I specifically authorize release of such information to the person(s) or category of person(s) indicated in this authorization.
5. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization
6. After I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 CFR 164.524.

This authorization will expire 12 months from the date of my signature (unless your state has specified shorter duration) unless you have specified a shorter duration or event. Shorter duration or event expiration date _____. If a resident of Indiana or Texas, this authorization will expire 180 days from the date of signature. If a resident of New Jersey, this authorization will expire 4 months from the date of signature.

Residents of Alabama: By checking this box, I consent to follow up upon release of my mental health records as authorized. ☐

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient's Representative)	**Date:**
Print Name of Patient (or Patient's Representative)	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:
Please provide supporting documentation (e.g. copy of Power of Attorney document).

☐ Power of Attorney ☐ Legal Guardian ☐ Surrogate Decision-Maker
☐ Executor or Personal Representative ☐ Parent ☐ Other : _____

Witness Signature (required if mental health or substance abuse records are being disclosed):_____

Print Name of Witness:_____
If in the state of Pennsylvania and patient is only able to give verbal authorization, need to have two witnesses sign this form.

Second Witness Signature_____

Print Name of second Witness:_____

For Select Medical use only: Name of facility disclosing records as authorized:_____
For Select Medical use only: If disclosing mental health or substance abuse information, document when the information specified has been released, by what means, and to whom it was sent:

_____

_____

Requestor's Phone Number:_____