Patient Label

AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION (PHI)

Mount Nittany Health
State College, PA 16803-6702

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

Patient Information: Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ E-mail: _____

Obtain Records From (check all that apply):
☐ MNMC ☐ MNPG (specify office if needed): _____ ☐ MNHV

☐ Other Facility: _____

Address: _____

Telephone: _____ E-mail: _____

Release Records To: Name of Person/Facility: _____

Address: _____

Telephone: _____ Fax: _____ E-mail: _____

Type of Information to be Released (check all that apply):

☐ All ☐ Abstract ☐ Entire Visit
☐ X-Ray, Imaging Reports ☐ Laboratory Test Results ☐ Procedures
☐ Immunizations ☐ Medication List ☐ Detailed Bill
☐ Behavioral Health Visits
☐ Notes (History & Physical, Consultations, Operative Reports, Discharge Summary, Progress Notes, etc.)
☐ Other (specify): _____

Treatment Dates of Service Requested: _____

Use of Information: The recipient listed above is permitted to use my PHI for (check one):

☐ Legal ☐ Personal ☐ Continued Medical Care – Appointment Date if known: _____
☐ Other: _____

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

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

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

☐ Information relating to HIV Test Results, AIDS, and AIDS-related illness

☐ 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.

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NOTICE OF DISCLOSURE

I hereby give consent for Mount Nittany Health (MNH) (including Mount Nittany Medical Center, Mount Nittany Surgical Center, Mount Nittany Physician Group, Mount Nittany Health Foundation, Children's Advocacy Center of Centre County, and Mount Nittany Health Ventures) to release and/or access all of my electronically available PHI. PHI may include information from my health care providers, including hospitals, physicians, clinics, pharmacies, labs, and other licensed providers, as well as a third-party organizations, like Health Information Exchanges, that assist in the exchange of my information.

I understand that the extent to which my PHI is accessed, disclosed or reviewed in connection with my care will vary and will depend on my clinical condition, the urgency with which my health care providers are responding to my medical condition and other factors. By consenting to an electronic exchange of my PHI, I understand that my health care providers are not guaranteeing review of every aspect of the exchanged health information.

Purpose: I acknowledge that my PHI that is electronically accessed by or disclosed to health care providers may be used to provide me with medical treatment, to assess or improve the quality of my medical care, and to facilitate public health reporting as allowed under the Health Insurance Portability and Accountability Act (HIPAA) and applicable Pennsylvania law.

Types of information included in this consent: I acknowledge that this consent permits MNH to access and/or disclose all my PHI. This may include but is not limited to information related to physical/sexual abuse, drug/alcohol abuse, HIV/AIDS, genetic diseases or genetic tests, family planning/reproductive care, sexually transmitted diseases, mental health, emergency care records, nursing notes, provider notes, laboratory results, pathology reports, x-ray reports and studies, and all other PHI as allowable under applicable law.

Charges: You may be responsible for payment of a reasonable, cost-based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information.

By signing this form, you acknowledge that this consent becomes effective immediately and will remain in effect for one year unless you submit a written request to revoke it. You have the right to withdraw or revoke the consent at any time by submitting your written request via email to MedicalRecords@mountnittany.org. Note that such revocation will not apply to any access or disclosure of your PHI completed prior to you cancelling this authorization.

This consent permits access to and disclosure of your PHI created both before and after the effective date of this authorization.

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.

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

_____

Witness Signature | Date | Time | Witness Signature | Date | Time

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: _____

OFFICE USE ONLY:
User ID: _____ Release Date:_____ DOS Released:_____ Total Pages: _____
Photo ID Obtained: ☐ Y ☐ N Driver's License #:_____
Received by: _____ Date: _____Time: _____
Transmitted by: _____ Date: _____Time: _____