

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
SAINT CATHERINE MEDICAL CENTER FOUNTAIN SPRINGS
101 BROAD STREET
ASHLAND, PA 17921**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

Persons/Organization providing information: _____ Persons/Organization receiving information: _____

Purpose of release (e.g. continue medical treatment, etc.) _____

The information to be released includes: _____ Dates of Treatment: _____

____ Discharge Summary ____ History & Physical ____ Operative Report
____ Pathology Report ____ Laboratory Results ____ X-rays: Reports
____ X-rays: Films ____ Consultations ____ Other as described below:

I understand that in order to process this request for the reproduction of medical record information on a timely basis, Saint Catherine Medical Center Fountain Springs may utilize a medical record copy service and, I further authorize the release on my medical record information to such record service for this purpose.

**SPECIAL AUTHROIZATION (IF UNDER 14 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN).
SIGN YOUR INITIALS NEXT TO THE INFORMATION TO BE RELEASED:**

_____ My evaluation, diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the consent above.

_____ My evaluation, diagnosis and/or treatment concerning mental health/rehabilitation may be released to the recipient noted on the consent above.

_____ My diagnosis and/or treatment for HIV/AIDS may be released to the recipient noted on the consent above.

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire in six months from the date of signature of automatically when the records requested on this authorization have been mailed to the requestor.

Date: _____ Time: _____ Signed: _____

Date: _____ Time: _____ Witness: _____

(If patient is unable to give consent because of physical condition or age, complete the following)

Patient is (a minor _____ years of age) unable to give consent because _____

Date: _____ Time: _____ Signed: _____

Signature of guardian/relationship