BUTLER HEALTH SYSTEM

MEDICAL RECORDS PH: 724-284-4530
FAX: 724-284-4532

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

There will be a per-page fee charged for Record requests.

1. **I hereby authorize the following BHS Facilities (please check all that apply):**
   ☐ Butler Memorial Hospital ☐ Primary Care Associates ☐ Clarion Hospital
   ☐ Butler Medical Providers: Please list each physician or physician's office

to release information from the record of:

_____ _____ _____
Patient Name Birth Date Unit Number

to the following: _____ _____ _____
Name of Facility/Person Phone Fax

2. **Records are requested for the purpose of (please check one):**
   ☐ Medical Treatment/Continued Care ☐ Insurance ☐ Legal ☐ Personal Use
   ☐ Other:_____
   Parts 1 and 2 must be completed to properly identify the records to be released.
3. **Format of Records Requested:** ( ) Paper Copies ( ) Electronic Media (unecrypted)
4. **Types of Records to be released and date(s) of service (Please check all that apply)**
   ☐ Inpatient: Dates_____ ☐ Outpatient testing-Dates _____
   ☐ Emergency Dept-Dates_____ ☐ Same Day Surgery-Dates _____
   ☐ Butler Medical Provider Physician Office Records-Dates_____
5. **Specific Information to be released** (check all that apply)

☐ History/Physical	☐ Mammography Report	☐ Cardiology Report
☐ Discharge Summary	☐ Nurses' Notes	☐ Physician's Orders
☐ Radiology	☐ Medication Administration Records	☐ Progress Notes/Office Notes
☐ Consultation Reports	☐ Operative Report	☐ Discharge Instructions
☐ Laboratory Reports/Test	☐ Pathology Report	☐ Emergency Department Records
☐ Other _____	☐ Slides	☐ Films

6. **HIV, Mental Health and Drug & Alcohol/Information contained in the parts of the records indicated above <u>will be released through this authorization unless otherwise indicated</u>.**
   Do not release: ☐ HIV ☐ Mental Health/Psychiatric ☐ Drug & Alcohol
7. I understand that this Authorization is effective for a six (6) month period from the date of signature unless otherwise specified. I understand that I may revoke this authorization in writing at any time except to the extent that Butler Health System or its affiliates or their respective employees or agents have acted upon this authorization. My written revocation must be submitted to the Privacy Officer, Butler Health System.
   <u>See side two of this form for additional patient rights and responsibilities.</u>

Patient Signature (14 years of age or older may authorize release of mental health information. A non-emancipated minor may authorize release of drug and alcohol treatment information) **Date/Time** **Signature of Authorized Representative** **Date/Time**

***Status of Authorized Representative (Proper paperwork required);**
☐Parent/Legal Guardian ☐Power of Attorney ☐Next of Kin ☐Executor of Estate

_____(Initial)- I authorize BHS facility to mail this information to the address above.

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses required)
Reason patient Unable to Sign Consent: _____

_____ _____
Witness Signature Date/Time Witness Signature Date/Time

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Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released
- Any drug or alcohol treatment records released will have the following statement accompany the records; "This
- Information has been disclosed to you from records protected by federal confidentiality rules."
- Release of my record will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records. I understand that it is possible that the facility/person
- That received the records may re-disclose the information, therefore 1) BHS and its affiliates, and their respective staff/employees have no responsibility or liability as a result of any re-disclosure and, 2) such information would no longer be protected by the Privacy Rule.
- I understand and authorize the release of records to the individual referenced herein using non-encrypted electronic media and that information on CD-ROM is not password protected. I understand and agree that neither BHS nor its affiliates, nor their respective staff/employees have any responsibility or liability if the protective health information is breached due to the media not being encrypted or being accessed by an unauthorized individual.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- I understand that I am no required to sign this Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b). Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plan(s) or government 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

- I am entitled to a copy of this completed Authorization form

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Hospital/Office use only:

Identity verified by Photo ID

Individual releasing records

Print Name clearly _____

_____

Signature Date/Time

03-18-22 dlm