Patient Name_____

MR # _____

or Patient Sticker Only

EXCELA HEALTH/EXCELA HEALTH MEDICAL GROUP
Authorization for Third Party Disclosure

Patient Name: _____ Date of Birth: _____ / _____ / _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____
_____ Request for copies of Record _____ Access to view record electronically

Entity to Release the records:

☐ **Westmoreland Hospital** ☐ **Latrobe Hospital** ☐ **Frick Hospital**

☐ **EHMG Office:** _____ ☐ **Other:** _____

I, _____ **, authorize the entity selected above to disclose health information as described below**
(Patient Name)

regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted diseases or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV) to:

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email Address: _____
Fax (Healthcare provider only): _____
Purpose of Disclosure: _____

I authorize the following information to be released from my medical record:
Date(s) of service: _____
Hospital (circle): Discharge Summary, History & Physical, Consultation, Operative Report, Pathology Report, Lab Results,
Diagnostic Testing (specify) _____, Radiology Report, Film/Image, Emergency Dept. Report,
Entire Record, Other (specify) _____
Physician Office (circle): Office Notes, Consultation, Health Maintenance, History, Lab Results, Radiology Results,
Other (specify) _____
Disclosure Format (Paper is default if not marked): Email (secure format) _____
_____ US Mail - paper format _____ CD/Flash Drive (secure format) _____ Fax (Healthcare provider only)
_____ Other (please specify): _____

- I understand that the information described above could possibly be redisclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing as described in the Excela Health Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event : _____. If I fail to specify an expiration date or event, **this authorization will expire in one year.**
- I understand that Excela Health/Excela Health Medical Group may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research-related treatment.
- I understand that I can request a copy of this completed authorization form.

_____
Signature of Patient/Customer or Legal Representative Date/Time

_____
If signed by Legal Representative, Relationship to Patient/Customer

_____
Signature of Witness Date/Time

VERBAL AUTHORIZATION (for persons physically unable to sign)
Not applicable to HIV or Drug & Alcohol Treatment Information. I witness that the patient understood the nature of this release and freely gave their oral authorization. (2 witnesses required)

Witness #1_____ Date/Time_____

Witness #2_____ Date/Time_____

7680021

Printed Name of Employee Fulfilling Request _____

Title:_____