Authorization for the Use and Disclosure of Protected Health Information by Other Entities to Warren General Hospital

Warren General Hospital - 2 Crescent Park West, Warren, PA 16365
Phone: (814) 723-3300 Fax: (814) 726-5796

Patient Name: _____ **Address**: _____

Date of Birth: _____ **Telephone**: _____

_____ I authorize _____ to disclose my protected health information to Warren General Hospital.

The purpose of this disclosure is: ___ Continuing Care ___ Patient Request ___Referral ___ Other (Specify)

Please disclose the following protected health information:

	Description:	Date(s)		Description:	Date(s)
	Complete Medical Record			Emergency Room Report	
	History and Physical			HIV testing and results	
	Discharge Summary			Behavioral Health (Psych) records	
	Consultation Report			Drug and Alcohol records	
	Operative Report				
	Laboratory/Pathology Report			Other (please specify)	
	Diagnostic Imaging Report				

- **I may revoke this Authorization at any time by signing the revocation section at the bottom of this form and sending a copy to the Privacy Officer, Warren General Hospital, 2 Crescent Park West, Warren, PA 16365. I understand that a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this Authorization.**
- **This Authorization will automatically expire in 1 year unless otherwise specified. I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I may be charged a reasonable clerical charge for costs incurred in making the records available and copied.**
- **Warren General Hospital will not condition medical treatment on my authorizing this release of information.**
- **Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**

For those individuals unable to sign this authorization:

I, _____, am unable to sign this authorization. My verbal consent to the above authorization and my verbal statement of my understanding of this authorization has been witnessed by two individuals whose signatures appear below.

_____ _____

Witness Date/Time Witness Date/Time

I have read and understood the contents of this form. I have been offered a copy of this form and I have ___ ACCEPTED ___DECLINED.

_____ _____ _____

Signature of Patient or Legal Representative Date Relationship (if a Legal Representative signs)

WGHAUTH

_____ _____

Witness Date

REVOCATION: I hereby revoke this Authorization. _____

Signature Date/Time