St. Mary Medical Center
Langhorne-Newtown Road, Langhorne, PA 19047

☐ Checked ID _____
(First Initial, Last Name)

Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS #: _____ Medical Record Number: _____

1. I authorize St Mary Medical Center to:
   ☐ Release Information to: ☐ Obtain Information from:

   Individual or Facility _____

   Address _____

   _____

   Phone _____ Fax _____

2. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

   Date(s) of Service: _____

   ☐ Face Sheet / Registration Sheet / Referral Sheet
   ☐ Discharge Summary
   ☐ ER Record
   ☐ H&P
   ☐ Consults
   ☐ Progress Notes
   ☐ Lab Results
   ☐ Radiology Reports
   ☐ EKG / Cardiology Testing Results
   ☐ Operative Report
   ☐ Pathology Report
   ☐ Medication List
   ☐ Entire Record (does not include the Extra Protected info listed in Section #3)
   ☐ OTHER: please specify _____

3. ☐ Behavioral Health Information ____ Initial
   ☐ Substance Abuse Information ____ Initial
   ☐ Human Immunodeficiency Virus (HIV) Information ____ Initial

I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).

4. This information for which I'm authorizing disclosure will be used for the following purpose:
   ☐ Sharing with other health care providers as needed ☐ Other (please describe): _____

   _____

5. 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 and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. Unless I specify differently, this authorization will expire six months from the date signed below:

   _____

7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

8. I understand that the use or disclosure of my health information is voluntary except in accordance with federal or state Law and any mandatory reporting requirements.

_____ _____ _____
Signature of patient or legal representative Date Time

If signed by legal representative, relationship to patient _____

_____ _____ _____
Signature of witness Date Time

A copy of this authorization form has been included with the copy of the medical record.
I have been offered a copy of this Authorization Form: Accept / Refuse Circle one and initial ____