FORM # HW-251-FF
Org 11/78 Rev 10/10

ACMH HOSPITAL
One Nolte Drive
Kittanning, PA 16201

Medical Record # _____

Date of Birth: _____

Authorization for Release of Information

I hereby authorize ACMH Hospital to release/obtain information from the medical record of:

_____ _____
Patient's Name (**PLEASE PRINT**) Date of Birth

This information is to be ☐ released to ☐ / obtained from:

_____
Person or Organization

_____
Address

_____

for the purpose of: _____

The information will be released when the authorization is received. Information regarding my treatment, hospitalization, and/or outpatient care, which WHEN CONTAINED IN MY RECORD, may include; psychological or psychiatric records, substance abuse (alcohol or drugs) Information, Human Immunodeficiency Virus (HIV) status, Acquired Immunodeficiency Syndrome (AIDS), or tests for HIV, unless specifically excluded (see below). I understand that in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above and will be effective until the date below. I understand that health information released pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal confidentiality laws. I understand that I may withdraw my permission at any time by written request (except for the information already disclosed).

I understand the specific information to be released is:

PATIENT'S TYPE OF SERVICE: ☐ IP ☐ SNU ☐ ARU ☐ SDC ☐ OBS ☐ ED ☐ OP

DATES OF SERVICE _____

DO NOT RELEASE: ☐ **HIV** ☐ **BEHAVIORAL HEALTH (Psychiatric)** ☐ **DRUG & ALCOHOL**

ITEMS TO BE RELEASED:

☐ Face Sheet	☐ Orders	☐ Labs	☐ EKG
☐ Progress Notes	☐ H&P	☐ Pathology	☐ Echo
☐ Physician Discharge Summary	☐ MAR	☐ X-Rays	☐ PFT
☐ Consults	☐ OR	☐ EEG	☐ Cardio Other: _____
☐ L&D Summary			

☐ PCS Electronic Documentation (PCS.ED.ROI) ☐ All Care Providers ☐ Specific Care Provider(s)_____

☐ PCS Discharge Summary

☐ PCS External Transfer

OTHER INSTRUCTIONS: _____

The authorization shall be in effect until _____ (60 days maximum).

"I understand that my ability to receive treatment does not depend on my signing this form"

_____ _____
Patient's Signature Date of Signature (Must be completed to be valid)

_____ _____
Signature of Legal Representative (only when Applicable) Witness or ACMH Hospital Staff member (as appropriate)

_____ _____
Relationship to Patient • Second Witness

• Two witnesses are required if patient signs by making a mark "X" or gives verbal consent.

Requesting Physician: _____ Date authorization sent: _____