LOCK HAVEN UNIVERSITY HEALTH SERVICES

401 N.FAIRVIEW ST.
LOCK HAVEN, PA 17745
PHONE: (570) 484-2276
FAX: (570) 484-2522

RELEASE OF INFORMATION

All portions of this form **must** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name	Date of Birth	Phone/Cell #
Street	City	State/Zip

I authorize the use and disclosure of health information about me as described below:**

Facility Authorized to Release my Health Information:

Agency or Individual (s) Authorized to Receive my Health Information

Health Information that may be used / discussed is limited to the following:

☐ Discharge Summary ☐ Consultation (s) ☐ Pathology Report ☐ Lab
☐ History & Physical ☐ Operative Note (s) ☐ Imaging X-ray ☐ Entire Record
☐ Other (specify) _____

COMMUNICABLE DISEASE (including HIV),Sexual Assault, Mental Health and Drug & Alcohol information contained in parts of the record above will be released through authorization unless otherwise indicated. DO NOT RELEASE, PLEASE CHECK:

☐ COMMUNICABLE DISEASE (including HIV) ☐ MENTAL HEALTH(Psychiatric) ☐ DRUG & ALCOHOL ☐ SEXUAL ASSAULT

Health Information that may be used/ discussed is limited to the following Treatment Dates:

Health Information to be released to the above named agency/ individual is to be used / disclosed for the following purpose(s) (include Research or Marketing, if appropriate):

"Health Information" Identifies you (the patient) by name, and includes other demographic information about you.
"Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If **research-related** Health Information is used or disclosed for continued research purposes, an expiration date or **event does not apply.**

This authorization will automatically expire at the completion of the present academic year, unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time. In writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, **refusal to sign** the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient /Authorized Person's Signature	Date	Time ☐ am ☐ pm
Relationship to Patient/Authority to Act on Patient's Behalf	Interpreter, if utilized	
Witness Signature	Date of Expiration	