

SECTION A (REQUIRED)

FULL NAME OF PATIENT: _____ DATE OF BIRTH: _____

Please select one of the following choices:

- (CHOICE 1) I authorize Hamot Health Foundation to disclose my health information as described below.**
- (CHOICE 2) I am the patient (or the patient's legal guardian, attorney-in-fact, etc.) and seek access to my own records.**
- (CHOICE 3) I authorize Hamot Health Foundation to receive the information described below from:**

(Name of Entity/Person Authorized to Disclose Information)

SECTION B (REQUIRED ONLY IF CHOICE 2 IS SELECTED IN SECTION A)

If this is a request to provide records directly to the patient, please select one of the following:

- I would like you to send a copy of these records to me at my address listed below. (Advance payment will be required.)
- The following person will pick up a copy of these records at the Medical Records office:

(Payment at time of pick-up will be required*.)
- I would like to make an appointment to look at these records at the Medical Records office.
(* The payment requirement may be waived when a patient is picking-up and hand-delivering records to another healthcare provider for further treatment. If this is your intention, please provide the name, address, and telephone no. of the healthcare provider who will ultimately be receiving the records, in the section below.)

If you are seeking records other than hospital records, please list each Hamot facility/office from which you wish to receive the described information: _____

(PLEASE NOTE: If you have listed any Hamot facility/office other than Hamot Medical Center, records may need to be sent from different locations, and there may be separate charges that apply. If left blank, only Hamot Medical records will be searched.)

SECTION C (REQUIRED)

NAME OF PERSON/ENTITY WHO WILL RECEIVE INFORMATION*: _____

ADDRESS: _____ TELEPHONE: () _____

PURPOSE FOR DISCLOSURE OF INFORMATION: _____

DESCRIPTION OF SPECIFIC INFORMATION PERMITTED TO BE DISCLOSED (INCLUDE DATES WHERE POSSIBLE): _____

I specifically authorize the disclosure of the following type(s) of information, if it is included within the information requested above:

- MENTAL HEALTH _____ (initials)
- DRUG AND/OR ALCOHOL ABUSE/TREATMENT _____ (initials)
- HIV STATUS _____ (initials)

This Authorization will expire upon the following date or event: _____

- I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that the entity disclosing the information has already relied upon it. In order to revoke this Authorization, I understand that I must revoke it in writing to Hamot Medical Center's Medical Records Department, where it involves Hamot records. (Revocation forms are available at the Medical Records office.) Where it involves another entity's records, I must revoke it in writing to the entity disclosing the records.
- I understand that the information disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy protections provided to me under the privacy laws that protect health information. (I understand, however, that re-disclosure of mental health, drug and/or alcohol abuse/treatment, or HIV information is specifically prohibited under Pennsylvania and/or Federal Law.)
- I understand that Hamot may not require that I sign this Authorization in order to obtain treatment.
- I understand that I have a right to request to inspect the information disclosed, or to get a copy at my expense, from the entity that I have authorized to disclose the information.

I have read this Authorization, or had it explained to me, and I understand its contents.

Signature: _____ Date: _____ Daytime Telephone: () _____

If this Authorization is signed by the patient's legal representative, the following is the legal basis for his/her authority to act for the individual:

- Power of Attorney** _____ (copy attached)
- Guardianship Order** _____ (copy attached)
- Parent of Minor** _____
- Executor/Administrator** _____ (short certificate attached)
- Other:** _____ (proof attached)

SECTION D (REQUIRED ONLY IF MENTAL HEALTH INFORMATION OR DRUG/ALCOHOL ABUSE/TREATMENT INFORMATION IS TO BE DISCLOSED)

Signature of Witness to Signature (Preferably Hamot Staff Member) : _____

Additional Witness Signature (Required only when patient is only able to make a mark): _____

PATIENT LABEL

Authorization for Disclosure of Health Information

D-30-24 (6-29-06)



HI0500

