Keystone Health

Patient Label

Keystone Family Medicine, Keystone Internal Medicine, Keystone Woman's Care, Keystone Pediatrics, Keystone Dental, Keystone Urgent Care, Keystone Community Health Services, Keystone Pediatric Development Center, Keystone Agriculture Worker's Program, Keystone Behavioral Health, Keystone Crisis Intervention, Keystone Foot and Ankle, Keystone Chiropractic.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
*****PLEASE READ AND COMPLETE ALL ITEMS*****

Patient Name: _____Allias/Maiden Name:_____

Date of Birth: _____ Last 4 of Social Security Number: _____

Address:_____

City:_____ State: _____Zip Code:_____

Home Phone:_____ Cell Phone:_____

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

To Obtain from: _____ (Practice/Service/Organization)	To Disclose To: : _____ (Practice/Service/Organization)
Address_____	Address_____
_____	_____
Fax: _____Phone:_____	Fax: _____Phone:_____

Description of Information to be disclosed or obtained:

Dates of Treatment: From: _____ To: _____
(Please Specify the Date of Service)

❑ **Abstract**: 2 years of medical records to include:
Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, Discharge Summary, Emergency Department Reports, Psychiatric and Psychological Evaluations, Mental Health Notes.

OR: Select specific documents to release/obtain.

❑ Laboratory Results ❑ Billing Statement ❑ Immunization Record ❑ Physician Progress Notes
❑ Outpatient Consult Notes ❑ Imaging (Keystone Health visits only) ❑ Medication/Problem List
❑ Dental Notes ❑ Dental Images ❑ Hospital Reports/H&P/DC Summary/Consults
❑ Therapy Progress Notes ❑ Psychiatric Progress Notes ❑ Psychiatric Evaluation
❑ Substance Use Treatment Notes ❑ Other _____

For the purpose of:

❑ Continuity of Care ❑ Transfer of Care (new provider) ❑ Insurance ❑ Legal ❑ Billing ❑ School Exchange ❑ Moving
❑ Employer ❑ Verbal Communication **Only** ❑ Other: _____

Method of Delivery ❑ Mail ❑ Fax _____ ❑ Email:_____
❑ Website:_____

Format ❑ Paper Copy ❑ Electronic Copy(Thumb Drive_____/CD_____)

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists.

Records **NOT** to disclose: ❑ Behavioral/Mental Health Services ❑ Substance Use Disorder (SUD) Visits

Other than the behavioral health and SUD visit information described above, I understand that the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, HIV/AIDS, and substance use disorder (for example, from primary care visits) and that by signing this authorization I am agreeing to the release of such information. *I can choose and have the right to have my records released directly to me so that I can review and inspect the materials, including for sensitive information I do not wish to be disclosed to a third party.*

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.
- This authorization expires one year from the date of signature unless otherwise specified as follows:_____/_____/_____.
- I Understand that if I am under the age of 17 and have consented to health services involving, reproductive, drug and alcohol, or mental health treatment, that my signature is required for any disclosure of such information.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

_____ _____

Signature of Patient/Representative Date

_____ _____

Print Name of Representative and Relationship to Patient Date

If patient is unable to consent or is a minor, complete the following: If signed by a person other than the patient, select the relationship.
Legal documentation may be required

Patient is:	☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority:	☐ Legal Guardian ☐ Custodial Parent ☐ POA ☐ Personal Representative ☐ Guardian ad Litem ☐ Executor of Estate ☐ Foster Parent ☐ Other_____

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

_____ _____

Signature of Responsible Person Date

_____ _____

Signature of Responsible Person Date

Forward To: Keystone Health, HIM- Release of Information Department
111 Chambers Hill Drive, Suite 200, Chambersburg, PA 17201
Phone Number: (717) 709-7960 Fax Number: (717) 217-1937
Email: khc-him@keystonehealth.org

****************Office Use Only********************

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____ 3/11/21, 5/9/23 ksw