

Authorization to use or Disclose Health Information

Patient Name: Last _____ First _____ MI _____

SSN _____/_____/_____ Medical Record # _____

Date of Birth: ____/____/_____

I authorize the use or disclosure of the above named individual's health information by Medical Staff or other agents of:

To use or disclose the following health information about me for the purpose of:

Hospitalization or Treatment Dates:

Type of Visit: Check all that apply ___ Inpatient ___ Outpatient ___ ED ___ Office ___ Other _____

Copies Requested:

- | | | |
|---|---|---|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Nuclear/Chemical Stress Test | <input type="checkbox"/> PET |
| <input type="checkbox"/> H and P | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Bronchoscopy |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Angiography | <input type="checkbox"/> Pulmonary Function |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Vascular Lab Studies | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> CTA | <input type="checkbox"/> Chemistry/BMP |
| <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> MRA | <input type="checkbox"/> CBC |
| <input type="checkbox"/> Imaging Study Copy, CD, Film | <input type="checkbox"/> CT | <input type="checkbox"/> PT/INR |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> MRI | <input type="checkbox"/> Other: _____ |

The Health Information described above may be used by or released to:

Commonwealth Surgical Services, Inc., Philip L. Rice, MD, 400 Highland Ave., Lewistown, PA 17044

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or dependency.

I read this form or had it read to me and I understand.

The authorization is valid starting (date): _____ ending: _____ (expiration date)

Signature of Patient: _____ Date: _____

Relationship if signed by other than patient: _____

Witness: _____

Philip L. Rice, M.D., FACS, FACC, FCCP, RPVI Commonwealth Surgical Services, Inc.
400 Highland Ave. Lewistown, PA 17044
Telephone 717-242-7939 Facsimile 717-242-7938

Authorization to use or Disclose Health Information

The patient is unable to sign his or her name. I attest that he/she has verbally authorized the use of disclosure indicated above.

Witness: _____ Witness: _____

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

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