BH/DA Authorization for the Use and Disclosure of Protected Health Information by Warren General Hospital to Other Entities

Warren General Hospital - 2 Crescent Park West, Warren, PA 16365
Phone: (814) 723-3300 Fax: (814) 726-5796

Patient Name: _____ **Address**: _____

Date of Birth: _____ **Telephone**: _____

_____ I authorize Warren General Hospital to use and/or disclose my protected health information to:

Person/Entity: _____ Address: _____
Telephone or Fax: _____

The purpose of this disclosure is: ___ continuing Care ___ Patient Request ___Referral ___ Other (Specify)
___ Determining evidence /extent of an addiction problem through evaluation

Please disclose the following protected health information:

	Description:	Date(s)	Description:	Date(s)
	Drug and Alcohol –insurance /funding source - Face sheet with limited PHI - Diagnosis(es) - Info consistent with 4 PA code §255.5		Psychiatric- insurance/funding source - Face sheet - Diagnosis(es)/treatment - Treatment recommendations & response - Medications - Follow-up treatment	
	D&A treatment notes		Behavioral Health (Psych) progress note(s)	
	History and physical		Laboratory/Pathology Report(s)	
	Medication List		Psych other (specify)	
	Discharge Instruction Sheet		Summary of care	
	D&A other (specify)		Psychiatric Discharge follow-up documents - History & Physical/ Psychiatric eval - Discharge instruction face sheet - Discharge summary - Medication list	
	Drug and Alcohol- treatment for next level of care - Dates of eval - cooperation with Level of Care recommendation - Recommendation for Level of Care/Diagnosis - Adherence w/ recomm. incl. dates - attendance at sessions - progress reports - knowledge of relapse - Termination date of treatment and reason for term.			

- **I may revoke this Authorization at any time either verbally or by signing at the bottom of this form and sending a copy to the Privacy Officer, Warren General Hospital, 2 Crescent Park West, Warren, PA 16365. I understand that a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this Authorization.**
- **This Authorization will automatically expire in <u>90 days</u> unless otherwise specified. I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I may be charged a reasonable clerical charge for costs incurred in making the records available and copied.**
- **Warren General Hospital will not condition medical treatment on my authorizing this release of information.** HGHAUTH
- **Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**

For those individuals unable to sign this authorization: I, _____, am unable to sign this authorization. My verbal consent to the above authorization and my verbal statement of my understanding of this authorization has been witnessed by two individuals whose signatures appear below.

_____ _____
Witness Date/Time Witness Date/Time

This form has been explained to me; I have read and understood its contents. I have been offered a copy of this document and I have ___ ACCEPTED ___DECLINED.

_____ _____ _____
Signature of Patient or Legal Representative Date Relationship (if a Legal Representative signs)

_____ _____
Witness Date

MR-1020-MM
066165
Rev'd
8.15.17

<u>REVOCATION</u>: I hereby revoke this Authorization. _____
Signature Date/Time