Authorization for Use and Disclosure of Protected Health Information

Patient Name:	DOB:
Address:	Phone:

I authorize the release of protected health information (PHI) from the medical records of the patient named above from the following Allied Services Integrated Health System entity(ies):

☐ Allied Services Behavioral Health Services
☐ Allied Services Center City Residence
☐ Allied Services Center City Skilled Nursing
☐ Allied Services Developmental Health Services
☐ Allied Services Home Health
☐ Allied Services Hospice and/or Palliative
☐ Allied Services In Home Services
☐ Allied Services Heinz Transitional Rehab Unit
☐ Allied Services Heinz Rehabilitation Hospital & Outpatient Centers
☐ Allied Services Meade Street Residence
☐ Allied Services Meade Street Skilled Nursing
☐ Allied Services Pharmacy
☐ Allied Services Rehabilitation Medicine Center
☐ Allied Services Skilled Nursing Center
☐ Allied Services Transitional Rehab Unit
☐ Allied Services Transitional Care Unit
☐ Allied Services Terrace
☐ Allied Services Vocational Services
☐ Allied Services Rehabilitation Hospital & Outpatient Centers

I authorize the release of PHI from the patient's medical record to:

Facility/Person to Receive Records:

____

Address: ____

Phone: ______________________________ Fax:______________________________

Email: ______________________________

Format:

☐ Paper ☐ Fax ☐ Email ☐ Other:

For the Purpose of:

☐ Insurance ☐ Legal Purposes ☐ Personal Use ☐ Continuity of Care
☐ Other: ____

Information to be released covers the time period from: ___________ to: ___________ and shall include the following:

☐ Consultations	☐ Discharge Summary	☐ History & Physical	☐ Physician Orders
☐ Physician Progress Notes	☐ X- Ray Report(s)	☐ Lab(s)	☐ Entire Record
☐ Other: ______________________			
☐ Therapy Initial Evaluation (Specify)	☐ PT	☐ OT	☐ Speech
☐ Therapy Progress Notes (Specify)	☐ PT	☐ OT	☐ Speech
☐ Therapy Discharge Notes (Specify)	☐ PT	☐ OT	☐ Speech

Medical record information disclosed under this Authorization may be subject to re-disclosure by the facility or person to whom such information is provided and may no longer be protected by the federal privacy rules.

Sensitive Information Requested:

I understand that the patient's medical record may contain sensitive information related to the testing, diagnosis, and/or treatment for any of the following conditions and understand this information may be released as part of the medical record.

Please check the appropriate box(es) below:

AIDS/HIV Information	Mental/Behavioral Health Treatment	Treatment for Substance Use Disorder
☐ Yes, disclose	☐ Yes, disclose	☐ Yes, disclose
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

I hereby authorize the Allied Services Integrated Health System entity(ies) noted above to disclose the health information described above. I understand I may revoke (cancel) this Authorization at any time by notifying the Allied Services Integrated Health System entity(ies) at the address(es) listed below in writing of my revocation. I understand that my decision to revoke does not apply to any release of records by any Allied Services Integrated Health System entity(ies) that may have taken place before the date of my revocation of the Authorization. This Authorization is voluntary. I understand that the patient's treatment by the Allied Services Integrated Health System entity(ies) or payment for services will not be affected if I do not sign this Authorization. I am entitled to receive a copy of this completed Authorization Form.

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I understand that information disclosed by this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

This Authorization will expire on ___/___/___, Event _______________, or One Year, unless otherwise specified.

_______________________________	_______________________________	_______________________________
Signature of Patient or Personal Representative	Print Name	Date/Time

____

Relationship of Personal Representative to Patient

____

Witness Signature Date/Time

AlliedServices
INTEGRATED HEALTH SYSTEM

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INSTRUCTIONS FOR COMPLETION:

1. Please complete the Authorization for Release of Medical Record Information Form in its entirety. Incomplete forms will be returned to the sender for completion.
2. The patient or legally authorized representative must sign and date the form. Generally, only a patient may authorize the release of his or her medical record information, subject to a few exceptions. See #4 below for the list of persons authorized to sign the Release of Medical Record Information Form.
3. If an individual signs with a mark such as an "X", there should be a witness signature attesting to the "signature" as being the individual. If an individual cannot sign due to physical impairment (this includes the making of a mark) but fully understands and is able to verbally consent, then notation of verbal authorization is to be made. One witness should attest to the patient giving verbal authorization.
4. Records will be sent directly to the party listed as the recipient on the Authorization Form.
5. The following is a list of persons authorized to sign the release of medical record information form:
    a. If the patient is 18 years of age or older and is competent, then the patient must sign. No one else is authorized to sign.
    b. Emancipated minors are authorized to sign on their own behalf. An emancipated minor is a minor age 16 or older who has left the parental household and established themselves as a separate entity. A minor who is married, is or has been pregnant, or who is a high school graduate is also considered emancipated. Emancipated minors can consent to their own treatment and the authorization for release of medical information.
    c. Minors are authorized to sign on their own behalf if they have been diagnosed with a venereal disease, treated for substance abuse or were treated to determine pregnancy.
    d. If the patient is between 14 and 18 years of age and consented to his or her own mental health treatment, the patient must personally sign.
    e. If the patient is between 14 and 18 years of age and the patient's legal representative consented to the patient's mental health treatment, either the patient or the patient's legal representative may sign.
    f. If the patient is over 18 years of age and is incompetent, then the legal representative must sign and provide proof of legal representative (e.g., a photocopy of power of attorney documents or other legal documents).
    g. If the patient is deceased, the executor of the remains may sign. In the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for release of information.

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Please Contact the appropriate Allied Services Integrated Health System facility if you have additional questions or need further assistance.

Facility/Service	Contact Information
Allied Services Institute of Rehabilitation Allied Services Rehabilitation Medicine Center Allied Services Outpatient Centers Allied Services Transitional Rehab Unit Allied Services Transitional Care Unit Allied Services Skilled Nursing Center	Health Information Department Allied Services Institute of Rehabilitation 475 Morgan Highway P.O. Box 1103 Scranton, PA 18501 570-341-4658
Allied Services Heinz Institute of Rehabilitation Allied Services Heinz Outpatient Centers Allied Services Heinz Transitional Rehab Unit	Health Information Department John Heinz Institute of Rehabilitation 150 Mundy Street Wilkes-Barre, PA 18702 570-830-8931
Allied Services Home Health	Allied Home Health c/o Director of Operations 100 Abington Executive Park Clarks Summit, PA 18411 570-348-2200
Allied Services Personal Care, Inc. Allied Services Continuing Care Retirement Community Allied Services Terrace	Administrator 100 Terrace Lane, Scranton, PA 18508 570-341-4350
Allied Services In-Home Services	In Home Services c/o Director of Operations 100 Abington Executive Park Clarks Summit, PA 18411 570-348-2205
Allied Services Developmental Services Allied Services Behavioral Health	Allied Services c/o Program Director 475 Morgan Highway P.O. Box 1103, Scranton, PA 18501 570-341-4642
Allied Services Pharmacy	Allied Services Pharmacy 475 Morgan Highway P.O. Box 1103, Scranton, PA 18501 570-340-4650
Allied Services Hospice &Palliative Care	Allied Services Hospice c/o Director of Operations 100 Abington Executive Park Clarks Summit, PA 18411 570-702-8733
Allied Services Meade Street Skilled Nursing Allied Services Meade Street Residence	Health Information Department c/o Health Information Clerk 200 South Meade Street, Wilkes Barre, PA 18702 570-823-6131
Allied Services Center City Skilled Nursing Allied Services Center City Residence	Health Information Department c/o Health Information Clerk 80 E. Northampton St. Wilkes-Barre, PA 18701 570-823-6131