TITUSVILLE AREA HOSPITAL

406 W. OAK STREET · TITUSVILLE, PA 16354
PHONE: (814)827-1851· MEDICAL RECORDS EXT. 2420 OR 2310· FAX (814) 827-3868

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to
(NAME OF INSTITUTION)
release information from the medical records of:

Patient: _____

Address: _____

_____

Birth Date: _____ Medial Record Number: _____

concerning hospital visit and/or treatment during the period from _____to
(DATE)
_____ to be released to:
(DATE)

_____

_____

_____

for the purpose of _____

Information includes:

_____ Summary Sheet _____ Consultations _____ O.R. Report s)

_____ Discharge Summary _____ Therapy Reports _____ X-ray Reports

_____ History & Physical _____ Lab Reports

_____ _____
(OTHER) (OTHER)

_____ _____
(OTHER) (OTHER)

This authorization will expire 60 days after the date signed below, unless revoked earlier.

_____ _____
(DATE) (PATIENT SIGNATURE)

_____
(LEGAL REPRESENATIVE)

_____
(RELATIONSHIP TO PATIENT)

This authorization must be signed by the patient or nearest relative/legal representative in the case of a minor or when the patient is physically or mentally incompetent to sign. The patient of the patient's legal representative has the right to revoke an authorization in writing to this facility. Any information disclosed following a patient's or their legal representative's authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the privacy rule. ✱ **You may refuse to sign this authorization** ✱ We may not condition treatment on whether or not you sign this authorization.

Revised 5/2017