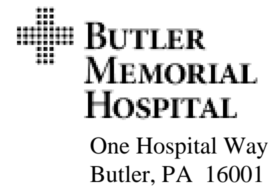
(PLEASE COMPLETE ALL AREAS MARKED WITH AN "X")



There will be a per-page fee charged for Record requests.

MEDICAL RECORDS PH: 724-284-4530
FAX: 724-284-4532

One Hospital Way
Butler, PA 16001

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize Butler Memorial Hospital to release information from the record of:

X________________________________ X____________________ X ____________________
Patient Name | Birth Date | Unit Number

To: X________________________________ X____________________ X ____________________
Name of Facility/Person | Phone | Fax

____
Facility/Person Address

Records are requested for the purpose of (**PROVIDE A DETAILED DESCRIPTION**):

X____
(Describe purpose – may include "at my request" if authorized by individual on whom PHI is kept)

Parts 1 and 2 must be completed to properly identify the records to be released.

X 1. Type of records to be released and approximate date(s) of service (check all that apply)

- ☐ Inpatient Dates ____
- ☐ Emergency Dept. Dates ______________________________________
- ☐ Outpatient Dates ____

X 2. Specific information to be released (check all that apply)

☐ Admission History/Physical	☐ Mammography Report	☐ EKG Report
☐ Discharge Summary	☐ Medical History and Physical Exam	☐ Physician's Orders
☐ Radiology/EKG/Lab Reports	☐ Medical Administration Records	☐ Progress Notes
☐ Consultation Reports	☐ Operative Report	☐ Discharge Instructions
☐ Laboratory Reports/Tests	☐ Pathology Report	☐ Psychology/Psychiatric Evaluations
☐ Other ____________________	☐ Slides	☐ Films

HIV, Mental Health and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

X **Do not release:** ☐ **HIV** ☐ **Mental Health/Psychiatric** ☐ **Drug & Alcohol**

I understand that this Authorization is effective for a one-year period from the date of signature, unless otherwise specified. I understand that I may revoke this authorization in writing at any time except to the extent that Butler Health System or its employees or agents have acted upon this authorization. My written revocation must be submitted to the Privacy Officer, Butler Memorial Hospital. **See side two of this form for additional patient rights and responsibilities.**

X ____________________ X _______/X_________ (OR) X____________________ X________/X________

Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment info.) | Date/Time of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below) | Date/Time of Signature

X__________________________ X _________/X__________
Witness/Staff Member Signature | Date/Time of Signature

*Authorized Representative's relationship and authority to act on behalf of patient: ______________________________

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses required)

______________________ _________/__________ ______________________ __________/__________
Witness # 1 | Date/Time | Witness # 2 | Date/Time

BUTLER MEMORIAL HOSPITAL

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Any drug or alcohol treatment records released will have the following statement accompany the records; "This information has been disclosed to you from records protected by federal confidentiality rules."
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records. I understand that it is possible that the facility/person that received the records my re-disclose the information, therefore 1) BHS and its staff/employees have no responsibility or liability as a result of any re-disclosure and, 2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- Butler Health System cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b), Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following:

  1. Whether the client is or is not in treatment
  2. The prognosis of the client
  3. The nature of the program
  4. A brief description of the progress of the client
  5. A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

- I am entitled to a copy of this completed Authorization form.
- Please return all mammograms and originals to X-rays.

Copy of authorization must be provided to patients when authorization is initiated by BHS and for all Drug and Alcohol Treatment Patients.

☐ Copy of authorization provided to patient.
☐ Copy of authorization refused.

Staff Use Only

☐ ID Obtained ☐ Signature Checked ☐ Other

Type of ID: ____________________

☐ Fee $ ☐ No Fee

Records Released by: ____________________ Date/Time Released: ____________________

☐ Mailed: ____________________ ☐ Picked Up ____________________ ☐ Courier