PATIENT ACCESS AND AUTHORIZATION FORM

Section A: This section must be completed for all Authorizations		
Patient Last Name	**First Name**	**MI**
Date of Birth	**Social Security Number (*optional):***	
My health information may be released to (name of recipient):		
Address 1:		
Address 2:		
City:	**State:**	**Zip:**

I hereby authorize the use or disclosure of protected health information as described below:
Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record (note exceptions in sensitive information section) ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests		☐ Nursing Information ☐ Discharge Summary ☐ Progress Notes ☐ Initial Evaluation ☐ Itemized bill: ☐ UB-92:		☐ Other: ☐ Other: ☐ Other:	

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also knows as Acquired Immune Deficient Syndrome (AIDS).
If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ Alcohol / Drug Abuse Treatment / Referral ☐ HIV/AIDS-related Testing and/or Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy notes)
☐ Genetic Testing – provide purpose of disclosure and to whom disclosed ______________________________
____
Please describe below the exact nature and dates of medical records that you would like to release (e.g., laboratory tests and results taken between January 1, 2007 and March 31, 2007). ______________________________

The purpose of requesting release of this health information is: ______________________________
____

I understand that:

1. If the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by the federal privacy regulations and may be redisclosed.
2. I may revoke this authorization in writing at any time, except to the extent that action has been taken by Select Medical Corporation in reliance on this authorization, by sending a written revocation to: Select Medical Corporation, Attn: Privacy Officer, 4716 Old Gettysburg Road, P.O. Box 2034, Mechanicsburg, PA 17055. However, I understand that if my participation in a mental health program is a condition for my release from confinement, probation, or parole, then I may not revoke this authorization.
3. I am not required to sign this authorization form and that Select Medical Corporation will not withhold the provision of treatment or payment to me as a condition of the signing of this authorization.
4. A copy or fax of this authorization form is as valid as the original.

This authorization will expire 12 months from the date of my signature (unless your state has specified shorter duration) unless you have specified a shorter duration or event. Shorter duration or event expiration date ______________________________. If a resident of Indiana or Texas, this authorization will expire 180 days from the date of my signature. If a resident of New Jersey, this authorization will expire 4 months from the date of my signature.

Residents of Alabama: By checking this box, I consent to follow-up upon release of my mental health records as authorized ☐

Patient Name:____

Patient Account Number or Medical Record Number:___________________________________

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient's Representative)	**Date:**
Print Name of Patient (or Patient's Representative)	
If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:	

☐ Power of Attorney ☐ Legal Guardian ☐ Surrogate Decision-Maker

☐ Executor or Personal Representative ☐ Parent ☐ Other : ____________________

Witness Signature (required if mental health or substance abuse records are being disclosed):____

Print Name of Witness:____

If in the state of Pennsylvania and patient is only able to give verbal authorization, need to have two witnesses sign this form.

Second Witness Signature___________________________________ **Print Name of second Witness:**________________________________

For Select Medical use only: Name of facility disclosing records as authorized:____

For Select Medical use only: If disclosing mental health or substance abuse information, document when the information specified has been released, by what means, and to whom it was sent:

____

____