MEADVILLE MEDICAL CENTER
Meadville, PA 16335

* A U T H R E L E A S E P H I *

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Form 60070 (Rev. 12/22)

I hereby authorize _____ to release information from the record of

Full Name _____ Birthdate _____ Social Security Number _____

to the following: _____

_____

_____

_____

for the purpose of (Not Required for Patient Requests) _____

Types of records to be released:

Inpatient Dates _____ Outpatient Dates _____

Emergency Department Dates _____ Clinic/Office Dates _____

Specific information to be released:

_____Discharge Summary	_____History and Physical	_____Physician Orders	_____Billing Records
_____Consultation	_____Operative Report	_____Pathology Report	
_____Laboratory Reports	_____Radiology Report	_____EKG	
_____Therapy Reports	_____Medication Administration Records		
_____Emergency Dept.	_____OTHER (Please Specify)		

Human Immunodeficiency Virus (HIV), Mental Health and Drug and Alcohol information contained in parts of the records indicated will be released through this authorization unless otherwise indicated:

DO NOT RELEASE: _____ HIV _____ Mental Health _____ Drug and Alcohol

I understand the following:
The release of my health information will be for the purpose stated above, if applicable, and only those items indicated will be released to the recipient named above.
The health information released by the facility/person authorized above may possible be re-disclosed by the facility/person that receives the information and therefore,
1) Meadville Medical Center and its staff/employees have no responsibility or liability as a result of the re-disclosure and
2) such information will no longer be protected by the Privacy Rule.
This authorization is in effect for a period of 90 days from the date of the signature, unless a specific time frame is documented, however, no time frame shall go beyond one year from the date of the signature.
Authorizations to release records to a patient have no expiration date.
That I have a right to revoke this authorization at any time by sending a written request to the entity where the authorization was provided.
That my decision to revoke the authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the authorization.
That my decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment.
That I am entitled to a copy of this completed authorization.
That I may be charged for these copies according to the fee schedule in effect at the time the copies are rendered.
My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.
The undersigned hereby agrees that any dispute or litigation commenced in connection with or as a result of the care provided to the undersigned at Meadville Medical Center shall be filed only in Crawford County, and further agrees that venue for any such dispute or litigation shall rest exclusively within said county.

Patient Signature _____ Date _____ Time _____ AM / PM

Signature of Parent, Legal Guardian or Authorized Representative* _____

* relationship and authority to act on behalf of patient _____ Date _____ Time _____ AM / PM

ORAL AUTHORIZATION (Two witnesses are required)
I witness that the person understands the nature of this release and freely gave their oral authorization.

Witness #1 _____ Date _____ Time _____ AM / PM

Witness #2 _____ Date _____ Time _____ AM / PM