

Patient Name _____
 MR # _____
 or Patient Sticker Only

**EXCELA HEALTH/EXCELA HEALTH MEDICAL GROUP
 Authorization for Third Party Disclosure**

Patient Name: _____ Date of Birth: ____ / ____ / ____
 Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____ Phone: _____

____ Request for copies of Record ____ Access to view record electronically

Entity to Release the records:
 ____ **Westmoreland Hospital** ____ **Latrobe Hospital** ____ **Frick Hospital** **EHMG Office:** _____

I, _____, authorize the Excelsa Health entity selected above to disclose health
 (Patient Name)

information as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted diseases or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV) to:

Recipient Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Email Address: _____
 Fax (Healthcare provider only): _____
 Purpose of Disclosure: _____

I authorize the following information to be released from my medical record:

Date(s) of service: _____
 Hospital (circle): Discharge Summary, History & Physical, Consultation, Operative Report, Pathology Report, Lab Results, Diagnostic Testing (specify) _____, Radiology Report, Film/Image, Emergency Dept. Report, Entire Record, Other (specify) _____
 Physician Office (circle): Office Notes, Consultation, Health Maintenance, History, Lab Results, Radiology Results, Other (specify) _____

Disclosure Format (Paper is default if not marked): Email (secure format) _____
 ____ US Mail - paper format ____ CD/Flash Drive (secure format) ____ Fax (Healthcare provider only)
 ____ Other (please specify): _____

- I understand that the information described above could possibly be redisclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing as described in the Excelsa Health Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event : _____.
 If I fail to specify an expiration date or event, **this authorization will expire in one year.**
- I understand that Excelsa Health/Excelsa Health Medical Group may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research-related treatment.
- I understand that I can request a copy of this completed authorization form.

 Signature of Patient/Customer or Legal Representative Date/Time

 If signed by Legal Representative, Relationship to Patient/Customer

 Signature of Witness #1 Date/Time

 Signature of Witness #2 (required for verbal release) Date/Time



Verification by (circle):
 Picture ID Signature Comparison Other: _____

Request completed by: _____
 Date: _____