



STAUNTON CLINIC
AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. **Failure to provide all information requested may invalidate this authorization.**

Patient Name: _____	Date of Birth: _____
Address: _____	Telephone #: _____
Date(s) of treatment: (Note: authorization is not valid <i>prior</i> to care being rendered.) From date: _____ To: _____	
The specific information to be disclosed from my medical/treatment records includes: _____ _____	
Purpose of Disclosure: _____	
Individual(s) or organization(s) authorized to use or disclose the Information: <input type="checkbox"/> Staunton Clinic Sewickley Valley Hospital, 720 Blackburn Road, Sewickley, PA 15143 <input type="checkbox"/> Other: _____	
Individual(s) or organization(s) authorized to receive the Information: Name: _____ Address: _____ Telephone: _____	
<p>PATIENT RIGHTS: I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed it may not be under the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. <i>If I have questions about the disclosure of my health information, I may contact the Medical Records Department or the Privacy Officer of Heritage Valley Health System.</i> I hereby certify that I have read this authorization and agree to its terms.</p> <p>I understand that my medical record may contain sensitive information relating to AIDS, HIV, psychiatric rare, and or treatment for drug and/or alcohol use. I give consent for use and disclosure of this type of information: (Please list exclusions, if any)</p> <p>_____</p>	
_____ Signature of Patient	_____ Date
_____ Print Name	_____ Date
_____ Signature of Witness	_____ Date
EXPIRATION: This authorization is valid for six months from the date of signature, unless the authorization is revoked by written notice.	