Memorial Primary Care
York Heart and Vascular Specialist

1600 Sixth Ave
Suite 105
York Pennsylvania
17403

TEL: 717-849-5576
FAX: 717-718-9972

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information from the
(Health Care Facility)

records of _____ to **YORK HEART AND VASCULAR SPECIALIST**
(Patient's name – include # to contact if needed)

_____ for the purpose of: _____

Specifically, the following reports will be included:

- _____ Discharge Summary
- _____ Operative Report
- _____ X-Ray Reports
- _____ Consultation Reports
- _____ Abstract of pertinent parts of record
- _____ History and Physical Examination
- _____ Laboratory Reports
- _____ Physician Progress Notes
- _____ Entire Medical Record
- _____ Other, please specify: _____

*Dates: _____

Types of Records: _____

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Pennsylvania Law. Act 63, and/or Pennsylvania P.L. 817, and/or Federal Public Law 93-282 and/or Pennsylvania Law, Act 148. Information disclosed from this authorization might be re-disclosed by the recipient and might no longer be protected by the Health Insurance Portability and Accountability Act if the recipient is not a covered entity.

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to at third party, such as for employee physicals, we may refuse to provide the service if you refuse to sign this form. Otherwise, your treatment will not be affected by your refusal to sign this form. I understand that I have no obligation whatsoever to disclose any information from my record and I understand that I may revoke this consent at any time by notifying Memorial Health Systems, in writing: and specifying a date, time, event or condition upon which my consent will expire. This will not prohibit Memorial Health Systems from completing any actions it initiated prior to my revocation and which rely on my records for completion. I have had this form read and explained to me and I understand its contents.

_____ _____
(Date of authorization)* (Print patient's full name)

_____ _____
(Signature of patient/authorized person) (Relationship to Patient)

_____ _____ _____
(Witness) (Patient's Date of Birth) (Social Security Number)

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:
We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

_____ _____ _____
(Date) (Signature of responsible witness) (Signature of responsible witness)

*The authorization expires 90 days from the date executed per state and federal law.