Attention: HIM Department
1855 Powder Mill Road
York, Pa 17402
Phone: (717)-848-4800
Fax: (717)-741-9867

OSS Health

Authorization to use or disclose Protected Health Information

This authorization gives OSS Health permission to use and/or disclose protected health information.

Patient Name:_____ **Birth Date:** _____

I authorize the use/disclosure of information about me as described below

To obtain from:	Disclose to:
☐ OSS Health	☐ OSS Health
Other:	Other:
_____	_____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Please specify dates of service:
from _____ **to** _____ **Body part:** _____

Release method requested

- ☐ Pick up: location: _____
- ☐ Patient Portal
- ☐ Mail
- ☐ Fax _____

Personal health information requested *(Information supplied via CD is in PDF format and is not encrypted)*

- ☐ Medical record abstract (history and physical, discharge summary, procedure report, laboratory/pathology reports, diagnostic/Imaging reports, medication listing, office visit notes)
- ☐ Physical Therapy
- ☐ Billing information
- ☐ Imaging reports
- ☐ Imaging studies on CD or email, please specify: _____
- ☐ Other Records as specified: _____

For purpose of:

- ☐ Continuation of care (second opinion, transfer, relocation)
- ☐ Disability
- ☐ Personal
- ☐ Other: specify _____

By signing this authorization, I understand that;

- Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Department attention Privacy Officer. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire on the following date/event/condition:**_____
  If I fail to specify an expiration date/event/condition, this authorization will **expire 120 days after date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized disclosure and apply to information may not be protected by federal confidentiality rules.
- I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse, HIV/AIDS, communicable diseases, domestic/sexual abuse, hepatitis, genetics, family history etc.. I may be charged for copies in accordance with state law or federal law.
- I have read and understand this authorization, and authorize use and disclosure of Health Information about the named patient as described in this authorization.

Signature of patient (18 years or older):_____ Date: _____

Signature of legal representative/relationship :_____ Date: _____

5/2025