AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

This authorization gives **OSS Health, PC, (OSS)** permission to use and/or disclose written/printed/electronic health information about you.

This authorization does not include disclosure of verbal information to authorized individual.

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

OSS Health
Attention: HIM Department
1861 Powder Mill Road
York, PA 17402
Phone: (717)-848-4800
Fax: (717)-741-9867

Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.

Authorized uses and disclosures

Print or type all information except signature.

1. **Patient Name:** **Birth Date:**

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2. 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.

Initials: ________

Revised 12/2016,4/2017

Personal health information requested:

___Discharge Summary
___Operative Report
___History & Physical
___Lab Report
___Other Records as specified: ____
___Films/Images: __MRI __CT __X-rays __Ultrasound
Please specify body part:
____
___Entire Medical Record

___Progress notes
___Radiology/Other Diagnostic Testing
___Billing Information

Release method requested:
___Paper ___CD ___Patient Portal
___ E-mail – secure you will be prompted to setup a password.
___ E-mail – not secure
Email Address: ______________________________

Note: Information supplied via CD is in PDF format and is not encrypted.

3. **I Authorize**-(Name of person or organization releasing information. Include address and phone number).
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4. **To Release Information To-** (Name of person or organization receiving information. Include address and phone number).
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5. Purpose of release/disclosure to other person/organization- Please check below:
___Continuing health care ___Disability ___Personal
___Second opinion ___Transfer of care ___Billing
___Employment determination ___Other, specify: ____________________

6. Expiration of Authorization- You ***must*** provide an expiration date. If no date is provided, the authorization will expire sixty (60) days from the date of your signature**.**
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Conditioning of Eligibility: OSS Health will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.

I have read and understand this authorization, and authorize use and disclosure of Health Information about the named patient as described in this authorization.

***If the patient is 18 years of age or older,** the patient must sign and date the form.
***If the patient is 18 years of age or older,** and is incapable of signing, a legally authorized substitute may sign and date the form.

Please indicate your legal authority and include documentation of your relationship.

___Legal Guardian or Conservator ___Health Care Agent (Power of Attorney)
___Parent ___Spouse

***If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign **a**nd date the form, unless an exception exists under state or federal law.

___Parent ___Legal Guardian

_______________________________________ _____________________________
Signature **(Required)** Date

____
Printed Name of Person Signing

Mailing Address of Patient: Phone:
____ ________________________
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