

NASON HOSPITAL

105 Nason Drive, Roaring Spring, PA 16673

(814) 224-2141

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release from the records of:
(Health Care Facility)

_____ to:
Patient's Name (Print First MI Last Name) Date of Birth

Or

Name of Person or Organization

Department

Street Address

City, State, Zip
 Fax to: _____

Nason Hospital, 105 Nason Drive
Roaring Spring, PA 16673

Mail	Fax	Department	Fax#:
<input type="checkbox"/>	<input type="checkbox"/>	Medical Records	(814)224-6252
<input type="checkbox"/>	<input type="checkbox"/>	Emergency Dept.	(814) 224-6255
<input type="checkbox"/>	<input type="checkbox"/>	ICU	(814) 224-6245
<input type="checkbox"/>	<input type="checkbox"/>	Med/Surg	(814) 224-6256
<input type="checkbox"/>	<input type="checkbox"/>	Day Surgery	(814) 224-6257
<input type="checkbox"/>	<input type="checkbox"/>	Home Health	(814) 224-6248
<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics/Nursery	(814) 224-6258
<input type="checkbox"/>	<input type="checkbox"/>	Radiology	(814) 224-6254
<input type="checkbox"/>	<input type="checkbox"/>	Lab/Pathology	(814) 224-6253
<input type="checkbox"/>	<input type="checkbox"/>	Occ Health	(814) 224-6267

The purpose of the request is : Patient Care Insurance Workers compensation Military Disability
Other: _____

Information to be released is: (Itemized portions of record and time period)

I authorize the inclusion of the following type of information, which I understand is specifically protected by federal/state statutes:

HIV/AIDS information Alcohol/drug treatment Mental health treatment

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance thereon. I will forward any such written request to revoke this consent to the Privacy Officer. This consent is valid for 3 months or until _____. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I can inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the receiving party.

If checked, I understand that Nason Hospital will be reimbursed by the organization to whom the information is being sent for the purpose of copying and providing this information.

Date of Signature

Patient's Signature

Witness

Signature of Responsibility Party & Relationship