Patient Name:_____ Date of birth:_____
Address:_____ Phone:_____
City/State/Zip:_____ Medical Record #_____

☐ I authorize Cole Memorial Hospital to **SEND** information **TO**:	☐ I authorize Cole Memorial Hospital to **RECEIVE** information **FROM:**
_____ Name of Provider/Person/Facility	_____ Name of Provider/Person/Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone # / Fax # (include area code)	_____ Phone # / Fax # (include area code)
_____ Attention	_____ Attention

Purpose for this request: (check all that apply)

☐Healthcare ☐Insurance Coverage
☐Patient Request ☐Legal Request ☐Other – specify _____

Type of information requested: (check all that apply and **MUST** include date(s) of service)

☐X-Ray reports ☐Operative Report ☐Discharge Summary ☐History & Physical
☐Laboratory test results ☐Complete medical record from:_____ to _____
☐Other (please specify) _____

Disclosure of Specially Protected Information: ☐DISCLOSE

☐Mental Health treatment ☐Drug and/or alcohol abuse treatment ☐AIDS or HIV status

Information that I wish **NOT** to have disclosed, if any, includes:

_____
_____

I understand that:

- I may revoke this authorization at any time by submitting a written request to the Health Information Management Department 1001 East Second Street, Coudersport PA 16915, except where disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care, medical insurance provider or otherwise not covered by privacy regulations; the information stated above could be re-disclosed and would no longer be protected by the privacy laws.
- My right to treatment cannot be conditioned on signing this authorization except when health services are provided solely for the purpose of disclosing information to a third party.
- A reasonable fee may be charged for the requested copies of the records.
- This authorization will remain in full force and effect until it expires 180 days from the date of this authorization or _____ (insert date)
- I have read the above and authorize the disclosure of the protected health information as stated. I also acknowledge that I may receive a copy of this form as requested.

Signature of Patient or Healthcare Agent/Representative_____ Date _____
Relationship to patient (if Agent/Representative)_____

Signature of Cole Staff_____ Date_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form #100714-7; Revised 2/3/15

AUTH

COLE Memorial