Wayne Memorial Hospital
Honesdale, PA 18431

Authorization To Obtain Health Information

Physician Specialty Clinics

* R O I *

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

Patient Phone Number: _____ Patient Email: _____

I hereby authorize the use/disclosure of the above-named individual's health information as described below:

Persons/Organizations <u>to provide</u> information:

☐ LVPG Urology
☐ Commonwealth Urology
☐ Commonwealth Pulmonology
☐ Commonwealth Gynecology
☐ Other Provider (write in): _____

Organizations <u>to receive</u> information:

Wayne Memorial Hospital
601 Park Street
Honesdale, Pa 18431
Phone 570-253-8263
Fax 570-253-8183

<u>RELEASE CONTENT</u> (Select all that apply)

Dates of Service (s)**: <u>Last 3 years of records & Most Recent Lab, in addition to the below</u>**.

□ **Complete Medical Record** □ **Abstract Medical Record**
X Provider Office Notes [Write Provider(s) Names]**:** _____

□ Radiology Images	**X** Lab Reports	□ Consult Reports	**X** Medication List
X Radiology Reports	**X** Pathology Reports	□ History & Physical (H&P)	□ Immunization Record
□ Cardiology Reports	□ Emergency Room Record	**X** Operative Report	
X Pulmonology Reports	□ Discharge Summary		

□ **Other** (Please Specify Other Record Type): _____

<u>SPECIALLY PROTECTED</u> I authorize release of information about the following specially protected information if it is contained within the medical record:

□ HIV □ Behavioral Health □ Substance Use/Abuse □ Sexually Transmitted Diseases

- I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information disclosed in response to this authorization may be subject to re-disclosure by the recipient, and will no longer be protected under the terms of this authorization.
- I understand I have the right to inspect or copy the health information to be used or disclosed as permitted by law.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable).
- I understand that Wayne Memorial Hospital may receive compensation for medical record copying in accordance with Pennsylvania law, 42 Pa.C.S. § 6152

<u>WMH SPECIALTY OFFICE:</u> Below, please select the WMH Specialty Practice that you would like to **<u>receive</u>** the above requested records.

□ Cardiology	□ GI	□ Nephrology	□ Pulmonology	□ Urology
□ Surgical	□ Neurology	□ Ortho	□ Gynecology	

Signature of Patient/Personal Representative_____ Date_____

If signed by personal representative, describe relationship to patient: _____

Affix Patient Label

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