AUTHORIZATION FOR RELEASE OF INFORMATION

Name on Medical Record:: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

I hereby authorize and request that: **AR Health**, 500 W 3rd St, Williamsport PA 17701
129 S Sparks St, State College PA 16801
570-322-8448 phone/570-322-8648 fax

Disclose Information *TO:* _____
Receive Information *FROM:* _
Exchange Information *WITH:*

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Purpose of Disclosure:_____**Date or Range of Dates of Requested Information:**_____

I request the release of the following information (INITIAL ALL THAT APPLY):

____ Complete Health Record	____ X-Rays	____ Lab Tests/Reports
____ Discharge Summary	____ Radiology	____ Case Management Notes/Reports
____ History and Physical Exams	____ EKG/EEG	____ Other (specify):_____
____Physician/Consultation Reports	____ Progress Notes	_____

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

_____Mental/Behavioral Health_____	____Sexually Transmitted Diseases
_____Developmental Disability _____	____HIV or AIDS
_____Alcohol/Substance Abuse	_____DNA Testing/Genetic Disorders
____Domestic Violence/Sexual Assault	_____ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

If requesting email delivery, you must initial and complete the following:

_____(initial) I hereby authorize that any of the information requested above may be delivered via secure, encrypted email to the following email address: _____

This Authorization is valid until (SELECT DATE NO MORE THAN 12 MONTHS FROM SIGNATURE):_____

(Continued)

I understand that this authorization is voluntary, and I may revoke this authorization at any time by writing to the address above. Any revocation does not apply to records already released in good faith pursuant to the above release. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I understand I have the right to inspect and copy the information being disclosed pursuant to this authorization. I understand that a medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not i sign the authorization, but it has been explained to me that if I decline to consent to this release of information, the following consequences may apply, as relevant: my providers may be unable to coordinate my care; I may be unable to apply for this program; and/or the requested records may not be released. Any copy of this authorization shall be considered as valid as the original.

Signature of Person Authorizing Release Date Signature of Witness (encouraged but not required) Date

_____ _____ _____ _____

NOTE: This Authorization must be completed in its entirety in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:_____