OSS Health
Attention: HIM Department
1855 Powder Mill Road
York, PA 17402
Phone: (717)-848-4800
Fax: (717)-741-9867

Authorization to use or disclose Protected Health Information

This authorization gives **OSS Health** permission to use and/or disclose protected health information.
Print or type all information except signature

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

I authorize_____
to release my medical records (Protected Health Information) to: □ Myself (include address) or list below

_____
Name and address of authorized person, doctor, hospital, agency or other

_____ _____
Phone Fax

Release method requested:
□ Paper □ Patient Portal □ CD (Information supplied via CD is in PDF format and is not encrypted)
□ Mail to □ Hold for pick up

Name:_____

Address:_____
Please specify dates of service and body part: _____

Personal health information requested:
□ Medical record abstract (H&P, discharge summary, operative report/procedure report, pathology, labs and x-rays)

□ Provider office note(s)	□ History & Physical	□ Medication record(s)
□ Lab result(s)	□ Discharge Summary	□ Billing information
□ Pathology	□ Operative Report/procedure report	□ Immunization record
□ Physical therapy/rehab	□ Hospital progress note(s)	□ Entire Medical Record

□ Other Records as specified: _____
□ Radiology reports Images: □ MRI □ CT □ X-rays □ Ultrasound

For purpose of:
___Continuation of care (second opinion, transfer, relocate) ___Disability ___Personal
___ Attorney ___Worker's compensation
___Other: specify _____

By signing this authorization, I understand that;

- Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Department attention Privacy Officer. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire on the following date/event/condition:**_____
  If I fail to specify an expiration date/event/condition, this authorization will **expire 90 days from the date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized disclosure and apply to information may not be protected by federal confidentiality rules.
- 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.
- I have read and understand this authorization, and authorize use and disclosure of Health Information about the named patient as described in this authorization.

Signature of patient (18 years or older): _____ **Date:**_____

Signature of legal representative: _____

Relationship to patient:_____ **Date:**_____

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