- ✓ **Allied Services Rehabilitation Hospital and Outpatient Centers**
- ▯ **Allied Services John Heinz Rehabilitation Hospital and Outpatient Centers**
- ▯ **Allied Services Home Health**
- ▯ **Allied Services Skilled Nursing Facility**
- ▯ **Allied Services In Home Services**
- ▯ **Allied Services Mental Health/Mental Retardation Services**
- ▯ **Allied Services Vocational Services**
- ▯ **Allied Services Housing**
- ▯ **Allied Terrace**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

1.

Name of Patient	**Birth Date**
Street Address	**City, State, Zip**

2. **AUTHORIZES:**

Allied Services
Name of Health Care Provider/Plan/Other

475 Morgan Highway
Street Address

Scranton, PA 18508
City, State, Zip Code

3. **RELEASE PROTECTED HEALTH INFORMATION TO:**

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

4. **INFORMATION TO BE RELEASED:**

___ Discharge Summary
___ History & Physical
___ X-Ray Reports
___ Consultations
___ Physician Progress Notes
___ Clinic Notes
___ Physician Orders

___ Therapy Initial Evaluation (specify type)
___ Therapy Discharge Summary (specify type)
___ Therapy Progress Notes (specify type)
___ Interdisciplinary Team Reports
___ Lab Results
___ Entire Record
Other (specify)

For the following dates ______________________________

*In compliance with the Pennsylvania Mental Health Procedures Act: Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.

Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

5. PURPOSE OF DISCLOSURE: (Check all that apply)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Personal
___ Changing Physicians
___ Other (Specify): ____________________

6. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. Your Rights with Respect to This Authorization:

- Right to Receive Copy of This Authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

- Right to Refuse to Sign This Authorization- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.

- Right to Withdraw This Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of Health Information Management at (570) 348-1462. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following date(s) ____________ or event(s)

(specify event) ____ .

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

9. **Signature of Patient:** ______________________________ Date: ____________

OR

Signature of Responsible Party: ______________________________ Date: ____________

Relationship to Patient: ______________________________

Patient is: ___ Minor ___ Incompetent ___ Disabled ___ Deceased

Legal Authority: ___ Custodial Parent ___Legal Guardian ___ Executor of Estate of Deceased
___ Power of Attorney for Healthcare ___ Responsible Party

Signature of Witness: ______________________________ Date: ____________