Cornerstone Family Health Associates
6 W. Newport Road
Lititz, PA 17543
(717) 627-2108

Authorization for Release, Use and Disclosure of Health Information

TO TRANSFER RECORDS FROM ANOTHER FACILITY TO CFHA
(INCOMING RECORDS)

_____
Patient Name | Maiden/Prior Name(s) | Birth Date

_____
Address | Town | State | Zip | Phone Number

Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. **The following organization is authorized to share and / or communicate**:

_____
Name of Office/Facility Releasing Records | Specialty

_____
Address | Town | State | Zip

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

☐ **Complete Medical Record**

☐ **Past 2 Years ONLY**
☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports

☐ **Abstract** of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

☐ X-ray and imaging reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other- list specific Items:_____

➢ **Behavioral Health Reports**:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission

☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol / drug abuse.

   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. **I understand that your facility may receive compensation for medical record copying in accordance with State law.**

5. **This information may be disclosed and / or discussed with my provider(s) at:**

Cornerstone Family Health Associates
6 West Newport Road
Lititz, PA 17543

For the purpose of:

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Inspection/Copying of my records

☐ Legal Investigation or Action ☐ Personal

☐ Changing Physicians ☐ Other (please specify):_____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. 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 payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #7 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 180 days, unless otherwise specified.**

_____ _____
Signature of Patient Date
(When signing for the patient, state your relationship and authority to do so below)

_____
Name of Patient (Please Print)

Patient is: **Minor** **Incompetent** **Disabled** **Deceased**

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased

☐ Power of Attorney for Health Care ☐ Authorized Legal Personal Representative

_____ _____
Signature of Witness Date

Revised 4/24/15