Allegheny Health Network

Saint Vincent

Saint Vincent Medical Group
Erie, Pennsylvania

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM SAINT VINCENT MEDICAL GROUP INTEGRATED ELECTRONIC HEALTH RECORD

Note to Recipient of Information: The patient's medical information is privileged and is protected by various State and Federal Laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

Many Saint Vincent Medical Group (SVMG) locations utilize an "integrated" Electronic Health Record which enables our providers and staff involved in the care of our patients to access and update their electronic health information for any SVMG location utilizing our "integrated" Electronic Health Record. Please see the last page of this document for a list of those SVMG locations utilizing our "integrated" Electronic Health Record.

1. I, _____ born _____
(Patient's Name) (Date of Birth)

_____
(Street Address) (City) (State) (Zip Code)

Authorize the SVMG location(s) utilizing an "integrated" Electronic Health Record indicated on the last page, to release the following information from my Integrated Electronic Health Record to the party listed in paragraph 3:

(Check appropriate items)
- ☐ Current Integrated Electronic Health Record information (all documentation as listed below)
- ☐ Other (Place an "x" next to each document listed below that you are authorizing to be released) for the following dates of treatment: _____

Requests for Current Integrated Electronic Health Record will include all documentation listed below if contained in the Integrated Electronic Health Record. The complete Integrated Electronic Health Record may also contain additional documentation not listed below.

___ Current medication list
___ Current problem list
___ Immunization record
___ Growth chart (pediatrics only)
___ Most recent physical exam
___ Office visits for the last 2 years or last 4 visits if not seen within 2 years
___ Consultation notes for the last 2 years
___ Test results for the last 2 years, with the exception of INR results, which only the last 3 results should be copied
___ Last discharge summary and H&P, if applicable

NOTE: Mental Health, drug/alcohol and/or HIV-related information if contained in the Integrated Electronic Health Record **will be released** through this authorization unless otherwise indicated. Check below if you do not want this information released.

___ Do not release mental health information
___ Do not release drug and/or alcohol information
___ Do not release HIV information

2. Indicate the format in which you want your documentation provided:

____ paper copy
____ electronic copy on DVD (A non-password protected DVD will be provided unless otherwise requested and technically possible)
____ password protected DVD (NOTE: password will be patient's date of birth in the following format (yyyymmdd) Ex. DOB 10/3/02 password would be=20021003. It will be the patient's responsibility to give the password to any other recipients.
____ Other _____

3. My medical information may be inspected by and/or copies may be released to:

_____
(Name of Recipient)

_____
(Street Address) (City) (State) (Zip Code)

for the purpose of _____
Note: unless otherwise stated the purpose is assumed to be at the request of the individual authorizing this release

4. I may revoke this authorization in writing at any time (except to the extent that actions have been taken in reliance upon it).

5. I understand that the SVMG Location(s) indicated below may not condition treatment on whether I sign this authorization.

6. Unless revoked or renewed in writing, this authorization will expire on (Date): _____.

7 I understand the possibility that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal Privacy Regulations.

SVMG Locations utilizing the "Integrated" Electronic Health Record

Indicate below the location(s) authorized for release of medical information from Saint Vincent Medical Group integrated electronic health record per this Authorization

___ Albion Family Medicine
___ Asbury Family Medicine
___ Children's Health Care West
___ Colorectal Physicians & Surgeons of PA
___ Digestive Diseases of NW PA Inc
___ East Harbor Primary Care
___ Edinboro Medical Center
___ Elk Valley Medical Center
___ Saint Vincent Dermatology
___ Gannon Student Health and Behavioral Services
___ Great Lakes Family Practice
___ Greater Erie Niagara Surgery
___ Liberty Family Practice
___ McClelland Family Practice
___ Millcreek Family Practice
___ Port Erie Family Medicine
___ Saint Vincent Allied Urology
___ Saint Vincent Bariatric and Metabolic Institute
___ Saint Vincent Cardiovascular Surgery
___ Saint Vincent Family Medicine Center
___ Saint Vincent Internal Medicine
___ Saint Vincent Sports Medicine
___ Saint Vincent Urgent Care East
___ Saint Vincent Vascular and Endovascular Surgery
___ The Center for Pain Management at Saint Vincent
___ Union City Family Practice
___ West Ridge Family Practice

If the expiration date is not specified above, this authorization will automatically expire 12 months from the date signed below.

_____ _____
(Patient's Signature) (Date Signed)

If patient is a minor, subject to a guardianship, power-of-attorney, or is deceased, I have signed my name below on behalf of the patient and myself.

_____ _____ _____
(Patient's, Legal Guardian's or Agent's Signature) (Relationship to patient) (Date)

I witnessed the signature on this form: Name of witness: _____

_____ _____
(Witness' Signature) (Date)