MOUNT NITTANY HEALTH

Fit for Play

Authorization to Release / Request Medical Information

Name: _____ Date of Birth: _____

Address: _____

I, _____ hereby authorize Mount Nittany Health Fit for Play to release/ request protected health information to/from another facility for the purpose of:

- ☐ Continuation of medical treatment
- ☐ Worker's compensation
- ☐ Insurance purposes
- ☐ Other: _____

Facility Name: _____

Address: _____ State: _____ Zip: _____

Specific Protected Health Information to Release / Request

- ☐ Initial Evaluation
- ☐ Progress Note
- ☐ Discharge Note
- ☐ Daily Notes
- ☐ X-ray Report
- ☐ X-ray Films
- ☐ Operation(s) Report
- ☐ MRI Report
- ☐ Other:

_____

_____

This authorization is valid from: _____ - _____ or 180 days from effective date. I understand that I may revoke this authorization at any time with a written notice by me. I also acknowledge the information disclosed with this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.