UNIVERSAL AUTHORIZATION FOR THE RELEASE OF SENSITIVE MEDICAL INFORMATION

Organization: ______________________

Patient Name: ______________________
Address: ______________________
____
Birthdate: ______________________
Medical Record No.: ______________________

We use an Electronic Health Record (EHR) to document and coordinate your care. Our EHR is a shared EHR maintained by Geisinger[1], and your protected health information (PHI) will be available to other entities who use the EHR when they have a treatment relationship with you.[2]

All the entities participating in our shared EHR will only disclose certain sensitive information with your consent. Unless required or permitted by law, we will not share information related to substance abuse disorder, your inpatient/involuntary mental health treatment records, or HIV/AIDS related treatment and testing records without your consent. **Here are the key points we want you to understand:**

- This authorization covers the complete release of your PHI, current and future, relating to substance abuse disorder, mental health, and HIV/AIDS (if they apply to you)
- By initialing and signing this authorization, you are giving permission to the entities that use our shared EHR to release this PHI for treatment, payment, healthcare operations[3] and other purposes permitted by law and as defined in our Notice of Privacy Practices
- PHI disclosed pursuant to this authorization may no longer be protected by federal privacy laws
- This authorization remains in effect until you revoke or cancel it.[4] To revoke this authorization, please submit a written request at your next visit to our office, or send a written request by mail to: Health Information Management Department, Release of Medical Information, MC 13-11, 100 N. Academy Ave. Danville, PA 17822
- If you choose to not sign this authorization, treatment or payment services provided to you will ***not*** be affected. Concerns or questions about this authorization? You may call the Geisinger Privacy Office at 570-271-7360

If you wish to share this PHI to facilitate treatment, payment, healthcare operations[3] and other important reasons that are permitted by law and defined in our Notice of Privacy Practices (such as helping with public health and safety issues), we ask that you review, initial and sign this authorization.

I hereby authorize all present and future covered entities (and their HIPAA business associates) using the shared EHR as described in our Notice of Privacy Practices to disclose the specific PHI below for treatment, payment, healthcare operations and other purposes allowable by law and as described in our Notice of Privacy Practices. The section below must be completed in its entirety.

Patient initials	Parent/Legal Representative initials	By initialing these 3 items, and signing below, I acknowledge that PHI regarding these topics may be disclosed as described above.
________	________	Substance use disorder (including alcoholism and drug dependency) records
________	________	Mental health (including inpatient and involuntary mental health/rehabilitation) records
________	________	HIV/AIDS (including evaluation, diagnosis and/or treatment) records

Patients who are age 14 or older, ***must*** date and sign ***below*** and initial ***all*** 3 items ***above*** in the box as the patient.

Patient Signature: ______________________ Date/Time: ______________

If the patient is an unemancipated minor under the age of 18[4], or if the patient is unable or unavailable to give consent, a parent or legal representative ***must*** sign and date ***below*** and initial ***all*** 3 items in the box ***above*** as Parent/Representative.

Parent/Legal Representative Signature: ______________________ Date/Time: ______________

Relationship to Patient/Legal Authority to Sign: ______________________

[1] The term "Geisinger" shall refer to the entire health care system comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities
[2] To learn more about our shared EHR, and how we use and disclose your protected health information (PHI), please see our Notice of Privacy Practices which lists the entities that participate in our shared EHR (now and in the future).
[3] Each as defined by HIPAA.
[4] If this form is completed by a parent or legal representative on behalf of patient who is a minor child, it will automatically expire at the patient's 18th birthday if it has not otherwise been revoked.

***** Patients: Please retain a signed copy of this document for your records *****
***** Staff: Please provide patient with a copy of the completed authorization*****

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