

**INSTRUCTIONS FOR COMPLETING THE
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM**

1. Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion. If the information to be disclosed is potentially related to reproductive health care, then the proposed *recipient* of such information shall complete the Attestation appended to the Authorization.
2. The patient or legally authorized representative (see #7 below) must sign and date the form. Electronic signatures are permitted to the extent that they are not prohibited by any applicable law. If you would like to use an electronic signature, please contact us and we will confirm whether it is permitted.
3. Please mail the form to Wayne Memorial Community Health Centers, 273 Grandview Ave, Suite 2, Honesdale, PA 18431; fax it to 570-253-8195; or email it to WMCHCMEDREC@wmh.org.
4. Except for a single consent for all future uses and disclosures for treatment, payment, and health care operations, records will be sent directly to the party listed as the recipient on the Authorization Form. We do not fax records to recipients unless needed for urgent patient care by another healthcare provider.
5. The following is a list of persons authorized to sign the disclosure of health information form:
 - Patients who are 18 years of age or older:
 - If the patient is competent, then the patient must sign. No one else is authorized to sign.
 - If the patient is incompetent, then the legal representative must sign and provide appropriate documentation (e.g., a photocopy of power of attorney documents or other legal documents establishing the authority of the legal representative).
 - Patients who are between 14 and 18 years of age:
 - If the patient received mental health treatment and consented to his/her own treatment, then the patient must sign.
 - If the patient received mental health treatment and the patient's legal guardian consented to the patient's mental health treatment:
 - The patient may sign; or
 - The legal guardian may sign if he/she is requesting: (a) the release of records to the patient's current mental health treatment provider; (b) the release of records to the patient's primary care provider (as deemed appropriate by patient's current mental health treatment provider); or (c) if the information is necessary for the legal guardian to consent to the patient's mental health treatment.
 - If the patient received drug/alcohol treatment, then the patient must sign.
 - If the patient received reproductive health services (including testing for pregnancy and prenatal care) and consented to their own treatment, then the patient must sign, and the parent(s) or guardian(s) cannot be notified of such services.
 - Patients who are under 14 years of age:
 - If the patient received mental health treatment, the patient's legal guardian must sign.
 - If the patient received drug/alcohol treatment, then the patient must sign.
 - If the patient received reproductive health services (including testing for pregnancy and prenatal care) and consented to their own treatment, then the patient must sign, and the parent(s) or guardian(s) cannot be notified of such services.
 - Patients who are deceased:
 - The patient's legal representative must sign and provide appropriate legal proof (e.g., a photocopy of executor documentation).

Please contact WMCHC at 570-253-8340 if you have additional questions or need further assistance.

**AUTHORIZATION TO DISCLOSE OR
OBTAIN HEALTH INFORMATION****Wayne Memorial Community Health Centers**

Patient Name (L, F):

Pt Account Number:

Date of Birth:

MUST CHOOSE ONE:Wayne Memorial Community Health Centers ("WMCHC") to release records to the party described in Section III.WMCHC to obtain records from the party described in Section III.**Section I: PATIENT INFORMATION****I hereby authorize the release of the records of the following individual:**

Patient Name:

Date of Birth:

Address: _____

Phone: _____

City/State/Zip Code: _____

Covering the period(s) of care (list applicable dates of treatment): _____

Section II: PURPOSE OF DISCLOSURE AND INFORMATION TO BE DISCLOSED**Information to be disclosed (check items to be released):**

Entire Record (May include Mental Health and/or Substance Use Disorder Information)

Other (please specify): _____

I understand that any information released pursuant to this request will not include any information related to testing or treatment I have received for AIDS/HIV unless specifically checked below.

Release AIDS/HIV related information

Purpose of disclosure of information:_____
_____**Section III: RECIPIENT OR RELEASOR OF INFORMATION****Based on the box checked in Section I, the information shall be released by WMCHC to or obtained by WMCHC from:**My treating providers, health plans, third-party payers (e.g., insurance), and people helping to operate this program
This option only available if the information is being released by WMCHC; otherwise, complete below

Name of Person or Institution: _____

Full Address: _____

Email address: _____ Phone: _____

Fax: _____

Preferred Delivery Method: _____

Section IV: EFFECTIVE DATE OF AUTHORIZATION AND REVOCATION

This authorization will expire (enter date or specific occupation): _____. The statement “end of the treatment,” “none,” or similar language is sufficient if the consent is for a use or disclosure for treatment, payment, or health care operations.

Except to the extent that action has already been taken to comply with this request, this authorization may be revoked:

- (1) in writing at any time, by writing to the address in the header of this form; or
- (2) verbally, by speaking directly with a representative of WMCHC at 570-253-8340.

After WMCHC receives your notice to revoke, it will terminate this authorization form within 5 business days. Prior to such termination, WMCHC may have shared some or all of your information or otherwise taken action in reliance on this authorization form; neither the organization nor any of its representatives are liable for any release of information during such time.

Section V: PATIENT RIGHTS AND OTHER IMPORTANT INFORMATION

- If the documents authorized for disclosure or use pursuant to this form are potentially related to reproductive health care, in WMCHC’s determination, then WMCHC shall obtain from the proposed recipient an attestation in the form attached hereto before disclosing any such information.
- You do not have to sign this Authorization Form. If you refuse to sign, it will not affect your ability to obtain treatment, or your eligibility for benefits (if applicable). However, your decision to refuse to give or revoke authorization may result in your insurance company not being able to pay for your care, and you may be responsible for such payment.
- You have the right to inspect the material to be released, subject to the limitations imposed by Pennsylvania laws and regulations including, if applicable, 55 Pa. Code Section 5100.33.
- WMCHC will provide a disclosure statement and a copy of this signed form along with all records it releases. The recipient of records pursuant to this form may be a HIPAA covered entity or business associate that receives records for purposes of treatment, payment, or health care operations, in which case the records released hereby may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.
- Once WMCHC discloses your health information to the recipient, WMCHC cannot guarantee that the recipient will not re-disclose this information to a third party or as required by law. The third party may not be required to comply with this Authorization Form or applicable law pertaining to the use and disclosure of your health information.
- WMCHC will notify you of its decision to approve or deny your request to access or obtain a copy of the requested information within 30 days of receiving this request if the information is maintained or accessible on-site or within 60 days if the requested information is not maintained on-site. If WMCHC is unable to comply with your request within the specified timeframes, it may extend the applicable deadline for up to 30 days by notifying you in writing.
- In accordance with federal and Pennsylvania state law, WMCHC may charge you for obtaining copies of records, except for copies sent directly to a healthcare facility or physician for continuing care purposes. WMCHC will bill you directly for any charges incurred. An invoice will be mailed to you and payment will be expected prior to the records being copied or released.
- You are entitled to receive a copy of this Authorization Form.
- If you are releasing medical records to WMCHC as a result of this form please send those records via email to wmchcmedrec@wmh.org; fax to 570-253-8195; **or** mail to Wayne Memorial Community Health Centers, 273 Grandview Ave, Suite 2, Honesdale, PA 18431

Section VI: PATIENT CONSENT

Written Consent to Release of Health Information:

I have read and understand this Authorization Form and the nature of my release of health information, and I authorize WMCHC to disclose or obtain my health information in the manner described above.

Signature of Patient or Authorized Representative

Date

Printed Name of Authorized Representative (if applicable)

Relationship to Patient

Signature of Witness

Date

Printed Name of Witness

Date

Verbal Release of Mental Health Information:

Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____ was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

Signature of Witness

Date:

Signature of Witness

Date:

Printed Name of Witness

Printed Name of Witness

A copy of this Authorization Form must be offered to patients when WMCHC initiates the authorization request, or when the authorization pertains to drug and/or alcohol use treatment records.

I would like a copy of this Authorization Form

I would not like a copy of this Authorization Form

For staff use only:

Signature of Staff Member Obtaining/Processing Consent

Date

Printed Name of Staff Member Obtaining/Processing Consent

**ATTESTATION REGARDING A
REQUESTED USE OR DISCLOSURE
OF PHI POTENTIALLY RELATED TO
REPRODUCTIVE HEALTH CARE**

Patient Name (L, F): 03/12/1941

Pt Account Number: 11/06/2025

Date of Birth:

Wayne Memorial Community Health Centers

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested PHI. <i>See fully-executed Authorization to Disclose Health Information.</i>
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure. Wayne Memorial Community Health Centers 273 Grandview Ave Suite 2, Honesdale, PA 18431
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting. <i>See fully-executed Authorization to Disclose Health Information.</i>

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

- The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.
- The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting the PHI

Date: 11/06/2025

Printed Name: _____

Organization / Title: _____