



## REGINA NURSING CENTER

550 East Formance Street  
Norristown, Pennsylvania 19401-3561  
(610) 272-5600

### Authorization to Disclose Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure: REGINA NURSING CENTER  
Address 550 EAST FORMANCE ST. NORRISTOWN, PA 19401

3. The type and amount of information to be used or disclosed is as follows:  
(include dates where appropriate)

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Most recent discharge summary
- Laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- EKG, X-ray and imaging reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Consultation reports from (doctors' names) \_\_\_\_\_
- Entire record
- Other Photo, NAME, AGE, ROOM NUMBER

4. 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 for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: GENERAL PUBLIC / WEB SITE MANAGER  
Address: \_\_\_\_\_  
For the purpose of MARKETING

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information manager. I understand that the revocation will not apply to information that has already been released

in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ONE YEAR AFTER DISCHARGE FROM REGINA . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized further disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health information manager for Regina nursing Center.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness