PeopleOne Health Altoona
2525 9th Ave Suite 2B
Altoona, PA 16602
P - 814-201-2835
F - 814-201-2895

I authorize the release of information from the record of: Name _____

DOB _____ SS# _____ Phone: _____

Release information FROM: PeopleOne Health/New Era Physician Services, _____,
PeopleOne Health Altoona.
Name of PeopleOne Provider

Release information TO: Name of Facility or Physician: _____

P: _____ F: _____ Address: _____

City, State, Zip: _____ Dates of Service: _____ to _____

Parts 1 and 3 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of services (check all that apply):

   ___ Inpatient ___ Outpatient ___ Emergency Department ___ Physician Office/Clinic

2. I authorize the release of: (check all that apply) contained in the records indicated above.

   ___Mental Health Information ___Drug and Alcohol

3. Specific information to be released (check all that apply):

   ___Consults ___ Radiology Report ___Operative Report ___EKG Report ___ Progress Notes

   ___ Medication Records ___ Discharge Summary/Instructions ___ Mammography Report

   ___ Medical History & Physical Exam ___ Pathology Report ___ Physician Orders

   ___Laboratory Reports/Tests ___ Emergency Dept. Report ___ Psychiatric/Psychological Eval

   ___ Other:

_____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ____ **Do Not Release if initialed**

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorize to release the information.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Patient

*Authorized representative's relationship to act on behalf of the patient _____
Parent/Guardian/Other

Oral Authorization (for persons physically unable to sign) NOT applicable to HIV Related Information or Drug & Alcohol Treatment Information
I witness that the patient understood the nature of this release and freely gave their oral authorization (two witnesses required)

_____ _____ _____ _____
Date Witness/Staff Member Date Witness/Staff Member