Patient Name _____

MR # _____

or Patient Sticker Only

Bartolomucci Family Medicine
120 Village Drive
Greensburg, PA 15601

I X _____ authorize X _____ to
(Hospital or Facility) your old office

disclose health information as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted disease or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV).

Patient's/Customer's Name X _____ Birthdate X _____

Information is to be used by or disclosed to: Bartolomucci Family Medicine

Address: 120 Village Dr, Greensburg PA 15601 724-420-5928 Phone
724-219-3120 Fax

For the purpose of: transition of care

Format Requested: (✓) Electronic Media Fax or CIOX DO NOT MAIL RECORDS

Description of information to be used or disclosed:

(✓) Face sheet
( ) Discharge Summary
( ) History/Physical
( ) Consultation date_____ physician_____
(✓) Operative report date_____
(✓) Pathology report date_____
( ) Other (please specify): _____

Dates of service: 2016 - present
(✓) Laboratory reports
(✓) Diagnostic testing report_____ date_____
(specify test) _____ date_____
(✓) Pathology slides
(✓) X-ray films/scans
(✓) EKG
( ) Emergency Department Records

- I understand that the information described above could possibly be redisclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- 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 as described in the Excela Health Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event: _____.
  If I fail to specify an expiration date or event, this authorization will expire in one year.
- I understand that Excela Health may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research-related treatment.
- I understand that I can request a copy of this completed authorization form.

X _____ X _____
Signature of Patient/Customer or Legal Representative Date/Time

_____
If signed by Legal Representative, Relationship to Patient/Customer

7680001

X _____ X _____
Signature of Witness #1 Date/Time

_____ _____
Signature of Witness #2 (required for verbal release) Date/Time

EXC 7680-001Ci (Rev. 1/14)