RURAL HEALTH CORPORATION
OF NORTHEASTERN PENNSYLVANIA
Administrative Office
276 East End Centre
Wilkes-Barre, PA 18702
T: (570) 825-8741 F: (570) 704-5308
www.rhcnepa.com

Patient Name: _____
First M.I. Last

DOB: _____ /_____ /_____

Address: _____
_____

Please check all the information requested:
___Immunizations ___X-Ray Report ___Lab Results ___History&Physical
___Other_____

For Dates of Services: _____ / _____ / _____ to _____ / _____ / _____

Reason for Medical Release:
___Healthcare Provider ___Medical Care ___Insurance ___Legal
___Other_____

I hear by authorize and request Rural Health Corporation of Northeastern Pennsylvania to release the following person or organization. The following will receive and use my protected health information:

Name: _____

Address: _____
_____

Fax: (_____)_____-_____ Email: _____

Select one of the following choices:

____This authorization will end on the following date: _____ / _____ / _____
____This authorization will end when the following event happens; The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below.
_____

Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

Signature of Patient (Legal Rep): _____

Name of Patient: _____ Date: _____/ _____ / _____