Mon Valley Community Health Services, Inc.
Primary Care - Receipt of Notice of Privacy Practices
2 East Gate Avenue Monessen, PA 15062

Print your name _____ Date of Birth _____

Address _____

I have reviewed and have been offered a copy of the Mon Valley Community Health Services, Inc. Notice of Privacy Practices.

Signature of patient or guardian if a minor _____ Today's Date _____

By placing my initials I authorize the following persons to receive information regarding me. _____

☐ No One ☐ Spouse ☐ Parents ☐ Other (see below)

First Name _____ Last Name _____ Relationship _____

First Name _____ Last Name _____ Relationship _____

Description of information that I authorize to be released (check all that apply):

☐ Any and all information related to my care and financial standing at Mon Valley Community Health Services

☐ Financial, billing, and insurance information

☐ Any and all medical information including reasons for tests, etc.

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed by will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by Federal or State law.

I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to the Privacy Office, Mon Valley Community Health Services, Inc. 2 East Gate Avenue, Monessen, PA 15062. I understand that my treatment will not be conditioned on signing this authorization. I understand I have the right to refuse to sign this authorization.

Signature of patient or guardian if a minor _____ Today's Date _____