



Welcome

Thank you for choosing Mount Nittany Physician Group to care for you. We hope to become your lifelong partner in health and wellness.

To prepare for your first appointment, please complete the attached forms. If possible, drop them off prior to your appointment, along with previous medical records and immunization records. You can also return them in the enclosed prepaid envelope.

Plan to arrive 15 minutes before your appointment, and bring your insurance card.

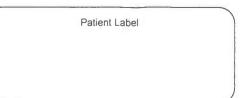
If you have any questions, call 814-466-7921 or visit mountnittany.org/newpatient.

We encourage all new patients to use the above link to sign up for our patient portal where you can access your records, pay bills and more.

Thank you. We look forward to meeting you soon!

New patient forms included:

- Authorization for release/request of PHI
- Registration Information





Authorization for Release/Request of Protected Health Information **Mount Nittany Health** Page 1 of 2

| MR#: | Acct #: | |
|--|--|---|
| | tany Health, consisting of Mount Nittangrelease or request my health information | y Medical Center (MNMC) and Mount Nittany n: |
| Patient Information: Name: | | Date of Birth: |
| Address: | | |
| | E-mail: | |
| Release Information To: Name | _: Mount Nittany Physician Group - Medica | l Records |
| Address: : 1850 E. Park Avenu | ie, State College, PA 16803 | |
| Telephone: | Fax: 814-231-7532 | E-mail: |
| Request Information From: Na | me: | |
| | | |
| | | E-mail: |
| Location of service (check all that | d or requested shall be <u>limited</u> to the follon at apply): MNMC MNPG (specific office) | ce if needed): |
| ☐ Pertinent MNPG (Office note: | ☐ Laboratory Test Results ☐ Operative Reports ☐ Office notes ultation, Operative, Pathology, Diagnostic) | X-Ray, Imaging Reports □ ED Records □ Discharge Instructions □ Progress Notes □ Medication List □ Other (specify): |
| The purpose of the disclosure is | as follows: Continuity of Care Lega | □ Personal □ Other: |
| ☐ Pick up ☐ Mail ☐ CD | leased or requested in the following manner Fax: Verbal | (check all that apply): |
| I understand that this release ☐ Information relating t ☐ Information relating t | may also include (Check to approve relead o AIDS or HIV infection | , |

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

White - Medical Record



Patient Label



Authorization for Release/Request of Protected Health Information Mount Nittany Health Page 2 of 2

| | Page 2 | of 2 |
|------|----------------------|------|
| MR#: | Acct #: | |
| | NOTICE OF DISCLOSURE | |

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

| Signature of Patient or Patien | nt Representativ | e | Print Name | | Date | Time |
|---|---------------------|----------------|--------------------|-------------------|--------------------|------|
| Witness Signature | Date | Time | Witness Sign | ature | Date | Time |
| If Patient is unable to give co | nsent or if a Ver | bal consent is | s given, two MNH | employees mu | st sign as Witness | ses. |
| If signed by Patient Represe | ntative, state rela | ationship and | authority to do so | : (check all that | apply) | |
| ☐ Parent of Minor ☐☐ Legal Guardian ☐☐☐ Power of Attorney for H | | | | | Legal Represent | |
| | atient Represen | tative | Date | | Time | |
| Office Use Only: Photo ID Obtaine Driver's License Other: Records Release Records Release Number of pages | #:ed on:ed by: | | | | | |
| Received by: Transmitted by:_ | | | Date | i | Time:_ Time:_ | |

White - Medical Record



PATIENT REGISTRATION INFORMATION

Emergency Contact (WILL NOT have access to personal/medical information)

| Contact Name (First and Last): | | |
|------------------------------------|-------------------------------|---------------|
| Relationship: | Phone Number: | Cell Landline |
| | | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | CellLandline |
| HIPPA Contact (WILL have access to | personal/medical information) | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | Cell Landline |
| | | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | Cell Landline |
| | | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | Cell Landline |
| | | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | Cell Landline |
| | | |
| Contact Name (First and Last): | | |
| Relationship: | Phone Number: | Cell Landline |