5-Hole 1/4 1 3/8 c-to-c

I authorize: ☐ **Abington Hospital** ☐ **Abington Lansdale Hospital** ☐ **Other** _____ (specify)
to release information from the record of:

_____ (Patient Name) _____ (Birth Date) _____ (MRN) as described below

To: _____ (Recipient of Protected Health Information) _____ (Phone) _____ (Fax)

_____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Please provide the patient's address (if different from above information) & phone number below:

_____ (Patient Address) _____ (Patient Phone Number)

Records are requested for the purpose of: (Please check one) ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

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

☐ Inpatient - Dates: _____ ☐ Emergency Dept. - Dates: _____

☐ Same Day Surgery - Dates: _____ ☐ Outpatient Testing - Dates: _____

2 The following information will be released with your electronic visit summary:

☐ Abstract(Discharge Summary, History & Physical, Operative/Procedure Report, Emergency Trauma Center Records, Labs, Radiology Reports, Cardiology Reports and Consults)	☐ Consultation Reports	☐ Rehabilitation Records
	☐ Discharge Summary	☐ Cardiology Reports
	☐ Emergency Trauma Center Record	☐ Physician Progress Notes
	☐ History & Physical Exam	☐ Psychiatric Evaluation
	☐ Operative/Procedure Report	☐ Radiology Report
☐ Medication Lists	☐ Pathology Report/Slides	☐ Images on CD
	☐ Nurses Notes	☐ Other: _____
	☐ Physician Orders	_____
	☐ Discharge Instructions	_____
	☐ Laboratory Tests/Results	☐ ENTIRE RECORD

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. **DO NOT RELEASE:** ☐ **HIV** ☐ **Mental Health** ☐ **Drug & Alcohol**

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 authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.**

If applicable, specify other expiration date/event here: _____

X _____ (SIGNATURE OF PATIENT) _____ (TIME) _____ (DATE)

OR

_____ (SIGNATURE OF RESPONSIBLE PARTY) _____ (TIME) _____ (DATE)

Relationship to Patient: _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased/Short Cert ☐ Power of Attorney for Healthcare

_____ (SIGNATURE OF WITNESS) _____ (TIME) _____ (DATE)

Please be aware that health care facilities are authorized by Pennsylvania State & Government Regulations to charge for the reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Abington Jefferson Health®

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Additional Patients Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Abington Health and its staff/employees have no responsibility or liability as a result of an redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- AHS cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- In accordance with 35 P.S. §7607 (e) pertaining to HIV-Related Information, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
- I am entitled to a copy of this completed Authorization form.