

Authorization to Release Protected Health Information

Section 1: Patient Information

PATIENT NAME		SOCIAL SECURITY NO. LAST 4 DIGITS ONLY		DATE OF BIRTH
PATIENT ADDRESS		CITY	STATE	ZIP CODE
				TELEPHONE NO.

Section 2: Location(s) of Care

Abington Hospital – Jefferson Health Abington Lansdale – Jefferson Health Other (if other location is selected – provide the specific location, address or physician practice/name where you received care):

Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self:

Address:

Fax#:

For the Purpose of: Continuation of Care Social Security/Disability Insurance Purposes Lay Caregiver

Legal Purposes Personal Access Other: _____

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Specific Information to Be Released

The information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

- | | | |
|---|---|--|
| <input type="checkbox"/> Abstract* | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Office Notes/Visit Notes | <input type="checkbox"/> Operations Report | <input type="checkbox"/> Imaging Films (X-rays, Scans, CD) |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Photographs |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Itemized Bills |
| <input type="checkbox"/> Disability/FMLA Form | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Catheterization Lab |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> Entire Record (includes records from other facilities) |
| <input type="checkbox"/> Problem List | <input type="checkbox"/> EKG, EEG, Stress Tests | |
| <input type="checkbox"/> Emergency Room Record | | |
| <input type="checkbox"/> History & Physical Exams | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Exception: I do not give permission to release (specify): _____

An abstract is a composite of the record that is most helpful to our patients and contains the information that is sent to physicians for continuity of care. The abstract contains the discharge summary, history and physical, consultation reports, all operations, diagnostic and laboratory results.

Authorization to Release Protected Health Information Form

1. Please complete all sections of the Authorization to Release Protected Health Information Form.
2. The patient or legally authorized representative must sign and date the form.

Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:

- emancipated minors may sign this form (a patient age 16 or older who has left the parental household, supports him/herself financially, and lives independently);
- minors who have married, been pregnant, or graduated from high school may also sign this form;
- minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
- minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.

3. Please mail the completed form to:

**Abington Hospital – Jefferson Health
Health Information Management
1200 Old York Road
Abington, PA 19001**

**Phone: 215.481.4435
Fax: 215.481.3139**

**Hours of Operation:
Monday – Friday 8:30 a.m. – 5:00 p.m.**

**Abington Lansdale Hospital – Jefferson Health
Health Information Management
100 Medical Campus Drive
Lansdale, PA 19446**

**Phone: 215.361.4959
Fax: 215.361.4871**

**Hours of Operation:
Monday – Friday 8:30 a.m. – 5:00 p.m.**

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- 4.

Please Note:

Jefferson will charge for copying records in accordance with State and Federal Laws.

<https://www.health.pa.gov/topics/Administrative/Pages/Medical-Record-Fees.aspx>

Jefferson will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

Jefferson may deny this request under limited circumstances as provided for under federal or state law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.

<p>Patients requesting mental health treatment records have the right to inspect the records to be released, subject to the limitations of 55 Pa. Stat. 5100.33.</p>
