



HUP PPMC PAH

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NAME

SEX M F

MR#

AGE / DATE OF BIRTH

ACCOUNT#

(PATIENT PLATE IMPRINT)

|   |  |  |                             |                                   |  |  |  |  |  |  |  |
|---|--|--|-----------------------------|-----------------------------------|--|--|--|--|--|--|--|
| Patient Name (First, Middle, Last)  |  | Date of Birth                                  |                             |                                   |  |  |  |  |  |  |  |
| Address   | City/State/Zip Code                          | Telephone Number                               |                             |                                   |  |  |  |  |  |  |  |
| <b>Disclosed Information:</b> (check all items to be released) <input type="checkbox"/> <b>Entire Record</b> <input type="checkbox"/> <b>Abstract</b><br><input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Lab Reports <input type="checkbox"/> Radiology Images<br><input type="checkbox"/> Discharge Instructions <input type="checkbox"/> ER Record <input type="checkbox"/> EKG/ECG Tests <input type="checkbox"/> Medication Records<br><input type="checkbox"/> History and Physical <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physician Orders<br><input type="checkbox"/> Consultations<br><input type="checkbox"/> Other (please specify) _____<br>Covering the period(s) of care (list applicable dates of treatment) _____ |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>Special Records:</b><br>I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below.<br><table border="0"> <tr> <td><u>AIDS/HIV Information</u></td> <td><u>Psychiatric Care/Treatment</u></td> <td><u>Treatment for Drug or Alcohol use/abuse</u></td> </tr> <tr> <td><input type="checkbox"/> Yes, disclose</td> <td><input type="checkbox"/> Yes, disclose</td> <td><input type="checkbox"/> Yes, disclose</td> </tr> <tr> <td><input type="checkbox"/> No, do not disclose</td> <td><input type="checkbox"/> No, do not disclose</td> <td><input type="checkbox"/> No, do not disclose</td> </tr> </table>  |  |  | <u>AIDS/HIV Information</u> | <u>Psychiatric Care/Treatment</u> | <u>Treatment for Drug or Alcohol use/abuse</u> | <input type="checkbox"/> Yes, disclose | <input type="checkbox"/> Yes, disclose | <input type="checkbox"/> Yes, disclose | <input type="checkbox"/> No, do not disclose | <input type="checkbox"/> No, do not disclose | <input type="checkbox"/> No, do not disclose |
| <u>AIDS/HIV Information</u>   | <u>Psychiatric Care/Treatment</u>            | <u>Treatment for Drug or Alcohol use/abuse</u> |                             |                                   |  |  |  |  |  |  |  |
| <input type="checkbox"/> Yes, disclose  | <input type="checkbox"/> Yes, disclose       | <input type="checkbox"/> Yes, disclose         |                             |                                   |  |  |  |  |  |  |  |
| <input type="checkbox"/> No, do not disclose  | <input type="checkbox"/> No, do not disclose | <input type="checkbox"/> No, do not disclose   |                             |                                   |  |  |  |  |  |  |  |
| <b>Location of Services:</b><br><input type="checkbox"/> HUP <input type="checkbox"/> PAH <input type="checkbox"/> PPMC <input type="checkbox"/> Penn Home Care & Hospice Service (PHCHS)<br><input type="checkbox"/> CPUP/CCA Outpatient Practice(s): _____ Other: _____   |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>Information To Be Provided To:</b><br>Name of Person or Institution _____<br>Address _____<br>City/State/Zip Code _____ Telephone Number _____   |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>Purpose/Use Of The Requested Information:</b><br><input type="checkbox"/> Personal use by patient <input type="checkbox"/> Sharing with other health care providers<br><input type="checkbox"/> Other (please describe) _____  |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>Format:</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Copy (provided on encrypted disk)  |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>Authorization</b><br>I hereby authorize Penn Medicine to disclose the health information described above.<br>I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.<br>I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing.<br>I understand the revocation will not apply to information that has already been released in response to this authorization.<br>My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.  |  |  |                             |                                   |  |  |  |  |  |  |  |
| Signature of Patient or Personal Representative   | Print Name                                   | Date   |                             |                                   |  |  |  |  |  |  |  |
| Relationship of Personal Representative to Patient  | Date   |  |                             |                                   |  |  |  |  |  |  |  |
| If Authorization is signed by someone other than the patient, please state reason. _____  |  |  |                             |                                   |  |  |  |  |  |  |  |
| <b>PLEASE READ INSTRUCTIONS ON REVERSE</b>  |  |  |                             |                                   |  |  |  |  |  |  |  |



DO NOT USE UNAPPROVED ABBREVIATIONS

## Instructions For Completing The Authorization For Disclosure of Health Information

1. Please complete all sections of the Authorization For Disclosure of Health information.
2. The patient or legally authorized representative must sign and date the form.

Generally, only a patient may authorize release of his/her medical information.

Exceptions to the rule are as follows:

- a. Authorization of minors – If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.
- b. Emancipated minors – An emancipated minor is a minor under the age of 18, who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.
- c. A minor who has been diagnosed with a venereal disease, a substance abuse problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.
- d. Authorization after death – An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
- e. Authorization of the incompetent patient – If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.

Penn Medicine reserves the right to request proof of representation.

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The address should be for Inpatient, Emergency Department, and APU/SPU records:

Hospital of the University of Pennsylvania  
3400 Spruce Street  
Medical Records Department  
1st Floor Founders  
Philadelphia, PA 19104

Presbyterian Medical Center  
Medical Records Department  
51 North 39th Street  
Myrin Basement  
Philadelphia, PA 19104

Pennsylvania Hospital  
Medical Records Department  
800 Spruce Street, 2nd Floor  
Philadelphia, PA 19107

Any Outpatient/Office Visit requests should be addressed to the individual Physicians' Office.

### Please Note

1. Penn Medicine will charge for copying records in accordance with Pennsylvania and New Jersey law, as applicable.
2. Penn Medicine 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.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law.
4. Penn Medicine will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information that is not maintained on site. If Penn Medicine is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
5. Penn Medicine may deny this request under limited circumstances as provided for under federal law. Penn Medicine will notify you if it denies your request to access or obtain a copy of the requested information. If Penn Medicine denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the Penn Medicine Chief Privacy Officer at the following address:

Penn Medicine  
Office of Audit, Compliance and Privacy  
3819 Chestnut Street, Suite 214  
Philadelphia, PA 19104

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