Authorization for Disclosure of Health Information

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

Disclosed Information: (check all items to be released) □ **Entire Record** □ **Abstract**

□□ Discharge Summary □ □ Operative Report □ Lab Reports □□ Radiology Images
□□ Discharge Instructions □ □ ER Record □ EKG/ECG Tests □ □ Medication Records
□□ History and Physical □ □ X-Ray Reports □ Progress Notes □ Physician Orders
□□ Consultations
□ □ Other (please specify) _____

Covering the period(s) of care (list applicable dates of treatment) _____

Special Records:

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.

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
□ □ Yes, disclose	□ □ Yes, disclose	□ □ Yes, disclose
□ □ No, do not disclose	□ □ No, do not disclose	□ □ No, do not disclose

Location of Services:

□ □ HUP □□ PAH □ □ PPMC □ □Penn Home Care & Hospice Service (PHCHS)

□ □ CPUP/CCA Outpatient Practice(s) : _____ □ Other: _____

Information To Be Provided To:

Name of Person or Institution

Address

City/State/Zip Code	Telephone Number

Purpose/Use Of The Requested Information:

□ □ Personal use by patient □ □ Sharing with other health care providers

□ □ Other (please describe) _____

Format: □□ Paper Copy □ □ Electronic Copy (provided on encrypted disk)

Authorization

I hereby authorize Penn Medicine to disclose the health information described above.

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.

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. _____

_____

PLEASE READ INSTRUCTIONS ON REVERSE

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.

The address to submit Inpatient, Emergency Department, and APU/SPU record requests:

Hospital of the University of Pennsylvania (HUP)
3400 Spruce Street
Medical Records Department
1st Floor Founders
Philadelphia, PA19104

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