

HUP PPMC

**PAH** 

NAME

MR#

AGE / DATE OF BIRTH

SEX M F

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

ACCOUNT#

(PATIENT PLATE IMPRINT) 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:** □ PPMC ☐ HUP □ PAH ☐ 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:**  $\square$  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.



DO NOT USE UNAPPROVED ABBREVIATIONS

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 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