Release of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

I authorize: _____to release my Medical Records

to: _____

Address: _____Phone/Fax _____

Covering the period(s) of Health Care: From: _____To _____

☐ **For purpose of continuation of care** ☐ **For personal use**

Is patient a minor? ☐ Yes ☐ No
If yes, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
If yes, Legal documentation provided ☐ Yes ☐ No

The information to be disclosed:

- ☐ **Complete Health Record**
- ☐ Inpatient Records
- ☐ History and Physical Examination/ Progress Reports
- ☐ Consultation Report
- ☐ Operative Reports
- ☐ Laboratory/X-ray Reports
- ☐ Other _____

I understand that my record may also include information relating to (check if applicable):

- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus); Confidentiality of HIV-Related Information Act, PA Law Act 148.
- ☐ Mental Health Information; PA Mental Health Procedure Act.
- ☐ Drug or alcohol information, Drug & Alcohol Abuse Control Act 42 CFR Part 2.

I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that my authorization will remain effective for a period of 90 days from the date of my request.

_____

Patient's Signature **Date**

_____

Signature of Authorized Person / Date **Relationship**

Information released by: _____ Date/Time: _____