PennState Health

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

DOB: _____ MRN #: _____

OR MUST PLACE FIN LABEL HERE

Penn State Health, Health Information Management, Mail Code CA700, P.O. Box 850, Hershey, PA 17033-0850 • Phone: 717-531-8055 • Fax: 717-531-5068

I. PATIENT INFORMATION:

Name: _____

Date of Birth: _____ Medical Record Number: _____

Phone: (_____)_____ Patient Email address: _____

REASON FOR REQUEST - please complete addressee field below in all cases:

- ☐ For patient's own use, including continuing care
- ☐ For Penn State Health to send medical information or images to another entity
- ☐ For requesting this patient's medical information or images to be sent from another entity to Penn State Health
- ☐ For a Penn State Health employee/agent to speak to another person or entity in person, by phone, or other communication media

I HEREBY AUTHORIZE _____
(Name of Authorized Employee, Agent, or Work Unit of Penn State Health)

TO DISCUSS MY HEALTHCARE INFORMATION (CHECK OPTION BELOW) WITH THE AUTHORIZED PERSON, AGENCY, INSTITUTION OR OTHER NOTED IN SECTION II.

- ☐ All medical information known by employee/agent about me.
- ☐ All medical information known by employee/agent related to treatment provided to me at Penn State Health.
- ☐ Other (Please specify): _____

☐ Other: _____

Please note there may be costs associated with requests for additional documents beyond what is provided in suggested Abstracts 1-3

Specific reason for request: _____

PLEASE SELECT FROM THE BOXES BELOW ANY SPECIFIC INFORMATION YOU WANT INCLUDED IN THIS DISCLOSURE:

☐ Behavioral/Mental Health ☐ Substance/Alcohol Use/Treatment ☐ HIV/AIDS ☐ Sexually Transmitted Infections (STIs)

WHERE DID YOU RECEIVE HEALTHCARE? PLEASE CHECK ALL THAT APPLY.

Penn State Health:

☐ Hershey Medical Center ☐ St Joseph Medical Center ☐ Pennsylvania Psychiatric Institute

☐ Holy Spirit Medical Center ☐ Hampden Medical Center ☐ Lancaster Medical Center

☐ Life Lion, LLC ☐ Clinic location _____

II. ADDRESSEE FIELD:

☐ **RECEIVE INFORMATION FROM:**	☐ **RELEASE INFORMATION TO:**
(Name of Patient, Authorized Person, Agency, Institution or other)	*(Name of Patient, Authorized Person, Agency, Institution or other)*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*

III. FORMAT IN WHICH YOU WOULD LIKE TO RELEASE OR RECEIVE MEDICAL INFORMATION:

☐ PSH Patient Portal ☐ Medical Record on Paper ☐ Medical Record on CD ☐ Other

☐ Radiology Images on CD ☐ Medical Records via secure email or OneDrive ☐ Fotofinder Images on Encrypted USB

IV. MEDICAL INFORMATION OR IMAGES BEING REQUESTED:

Please provide the type(s) of medical records information requested by checking the boxes and listing their dates of service below:

(List dates of service here) _____

(See Next Page)

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☐ **Abstract 1: INPATIENT Medical Records (Up to 2 years old):**
Provides Consult, Diagnostic Test Results, Emergency Department & Discharge Summaries, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Lab reports

☐ **Abstract 2: OUTPATIENT Medical Records (Up to 2 years old):**
Provides Consult, Diagnostic Test Results, Emergency Department, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Outpatient Letter, Outpatient Clinic Notes, Lab reports.

☐ **Abstract 3: Only Diagnostic Test Result(s) (Up to 2 years old):**
For example, Radiology, EEG, EKG, Cardiology Studies, Pathology, Pulmonary Studies
(specify Type of Test & Date) _____

☐ **Other:**

- ☐ Discharge Summary(ies) Reports
- ☐ History & Physical Reports
- ☐ Laboratory Results
- ☐ Serial #/Product ID # for implanted devices
- ☐ Fotofinder Images
- ☐ Outpatient Letters/Notes Reports
- ☐ Daily Progress Notes Reports
- ☐ Operative Report, Procedure Reports
- ☐ Radiology Image(s) – specify type and date
- ☐ Other **(please specify what document and date of services)** _____

Behavioral/Mental Health Records up to 2 years: ☐ Psychiatric Evaluation ☐ Discharge Summary ☐ Other: _____

Please contact HIM with any questions or concerns at 717-531-8055

V. PATIENT OR REPRESENTATIVE SIGNATURE:

This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form, to the attention of the Director, Health Information Management. If not previously revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at Penn State Health. Neither our treatment nor your payment is conditioned upon your signature on this form.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

_____ _____
Signature of Patient or Representative *Date/Time*

_____
Relationship if signed by other than Patient

☐ Verbal consent to release information to patient or another covered entity was received.

NOT Applicable to HIV-related Information or Drug & Alcohol Treatment Information
I witness that the patient/parent/legal guardian understood the nature of this release and freely gave their oral authorization (Two Witnesses are required)

_____ _____ _____ _____
Witness # 1 *Date/Time* *Witness # 2* *Date/Time*

_____ _____
Information Released by *Date/Time*

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.

This document authorizes release of information entered into my medical record prior to or within 12 months after the date of my signature

PLEASE RETURN THIS FORM IMMEDIATELY TO HEALTH INFORMATION MANAGEMENT @ 717-531-5068

Note to recipient of information: This information has been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.