Authorization to Obtain or Release Protected Health Information

INSTRUCTIONS on page 2.
PLEASE COMPLETE ALL SECTIONS ON THE AUTHORIZATION FORM

Attach patient label OR fill in information below.

Patient Name: ____ Date of Birth: _______________________________

Phone Number: ____ Admission Date: _____________________________

I authorize Friends Hospital to obtain information from and/or release information to:

____ ___________________ ___________________
Name of Person or Entity | Phone Number | Fax Number

____ ____
Street Address | City, State, Zip

Additional Instructions: ____

Friends Hospital, 4641 Roosevelt Blvd, Philadelphia, PA 19124, Phone: 215-831-4600, Medical Record Fax: 215-831-4789

Please **INITIAL** below to signify that you consent to the additional specific information to be released to the above individual/entity:

______ Drug/Alcohol Related Information

______ HIV or AIDS Related Information

______ Psychiatric/Behavioral Health Information ______ **Do Not** release the following:_____________________________

Information to be released:	☐ Verbal Communication	☐ Clinical Referral Packet
☐ Discharge Summary	☐ Abstract of Record (key components)	☐ Entire Record
☐ Physician's Psychiatric Evaluation	☐ History and Physical Exam Report	☐ Discharge Information/Continuing Care
☐ Nursing Assessment	☐ Psychosocial Assessment	☐ Initial Intake Assessment
☐ Medication Summary	☐ Lab/Study Results	☐ Other (Specify):_____________________

Purpose for which this Information is to be used:	☐ Continuing Care	☐ Collateral Contact	☐ School
☐ Legal (must give specific reason): ________________	☐ Employment	☐ Disability Benefits	☐ Personal

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This Release of Information demonstrates compliance with HIPAA Standards for privacy, and all Federal and State guidelines. I have been informed to refer to the Notice for Privacy Practices regarding authorized disclosures. I confirm a legible copy of this authorization or my signature thereon may be used with the same effectiveness as an original. "Federal regulation (**42 CFR, Part 2**) prohibits anyone from making any further disclosure of this information unless it is expressly permitted by my written consent, or as otherwise permitted within such regulations. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." **[RM 203, 7.2] Rev. 4-12-04**. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing.

Validation: This authorization is in effect beginning ________________ and expires _________________ (not to exceed 180 days).

____ ___________________
Patient Signature ***(including minor patients age 14-17)*** | Date

____ ___________________
Parent/Guardian/Authorized Representative Signature (if applicable) | Date

____ ___________________
Witness Signature | Date

Revocation: *I hereby revoke the above authorization – Signature:* ________________________________ *Effective Date:* _____________

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INSTRUCTIONS on page 2.
PLEASE COMPLETE ALL SECTIONS ON THE AUTHORIZATION FORM

Section 1: **PATIENT INFORMATION**

- *Fill in your name, date of birth, and a current phone number where you can be reached.*
- *Fill in the admission date of the encounter that you want released.*

Section 2: **RELEASE TO / OBTAIN FROM**

- *Fill in where you want the information to go or where we should obtain it from.*
- *Please fill in the entire address.*
- *Use the additional instructions line to add a contact name and fax if it is to be returned to a specific individual at Friends Hospital.*

Section 3: **INITIAL FOR SPECIFIC INFORMATION**

- *You must put your Initials on each line, for each type of information that pertains to you.*
- *If you do not want to release certain specific information, fill it in on the line provided.*

Section 4: **SPECIFY DOCUMENTS**

- *Choose the documents you want released.*
- *We have 30 days to comply with your request, but often complete it much sooner.*
- *Charges for discharged record copies may apply, as allowable by the State of Pennsylvania.*
- *We do not charge for copies sent for continuity of care.*
- *A Release of Information Representative will contact you with details of any fees.*
- *A Discharge Summary can often be given to you at the time you fill out an authorization.*
- *Please bring an official ID if you are picking up your records.*

Section 5: **REASON FOR REQUEST**

- *Check the purpose of or need for your records.*
- *If it is for legal purposes, please fill in the reason.*

Section 6: **AUTHORIZATION VALIDATION**

- *Read the Statement.*
- *Fill in the Validation Dates for the authorization. Start from the* ***current date*** *you are filling out the form, to the* ***future date*** *you want it to expire – up to 180 days or 6 months.*

Bottom Section: **SIGNATURE**

- *Sign and Date the document.*
- *Parent, representative, or witness signatures may be added if necessary.*
- *Remember, you have the right to revoke this authorization to the extent it has not yet been acted upon.*

Please mail your request to Friends Hospital, Attn.: Medical Records, 4641 Roosevelt Blvd., Phila., PA 19124, or you may bring it personally to the office for service, between the hours of 8:30am to 4:00pm.

Please note that we are allotted 30 days to complete your request.