AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Birth Date: ______________

Maiden/Prior Names: ______________________________ Current Phone #: ______________

Current Address: ______________________________ Last 4 of SS#: ______________

To be released to or requested from: ☐ Self (address above)

☐ ______________ Agency/Organization (_____)______________ Telephone Number ______________ Street Address

______________ Name / Attention to (_____)______________ Fax Number ______________ City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: ______________
☐ Verbal Exchange of Information ONLY ☐ Other: ______________

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: ______________

Dates of Service requested ______________________________

☐ **I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, and/or psychiatric or behavioral Information and treatment, or**

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Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☐ Psychiatric Evaluation
☐ History and Physical
☐ Discharge Summary
☐ Progress Notes
☐ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: ______________
☐ Abstract / Entire Chart

This authorization will expire on _______/_______/20_______. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

______________ **Patient's Signature (required for ages 14 and older)** ______________ Parent/Legal Guardian Signature (if applicable) ______________ Relationship to Patient ______________ **Date Signed**

______________ Witness Signature/Credentials ______________ Date Signed

This authorization is intended to allow **Friends Hospital** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

Revocation:

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request..

______________ Revocation Signature ______________ Date/Time

FRIENDS AUTHORIZATION INSTRUCTIONS AND MAILING ADDRESS

Patient Information →

Where to Send and to Whom →

How to Send →

Reason for Request →

Dates Patient was here →

Check one box ONLY… to include or to exclude certain information →

Check off the Documents you are requesting →

Add a future Date that this Authorization expires →

Patient Sign and Date →

Not needed unless revoking Authorization →

Auth. Instructions Rev. 6/22/22

FRIENDS HOSPITAL

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☐ History and Physical ☐ HIV Test Results and AIDS Treatment Records
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______________ Revocation Signature ______________ Date/Time

Authorization Release of Information Form revised 6/22/22

Please Note: We have 30 days to comply with your request. Charges for record copies may apply, as allowable by the State of Pennsylvania. You will be contacted concerning any fees. You must bring an official ID if you are picking up your records. Please call if you have any further questions. **215 831 3917**

Mail to: **Friends Hospital**
Attn: Medical Record s
4641 Roosevelt Blvd.
Philadelphia, PA 19124