HEALTH INFORMATION MANAGEMENT DEPARTMENT
1648 HUNTINGDON PIKE
MEADOWBROOK, PA 19406

MRN: ____________________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:		Date of Birth:
Street Address:	City, State Zip Code:	Patient's Phone:
Recipient's Name:		Recipient's Phone:
Recipient's Street Address:	City, State Zip Code:	Recipient's Fax:

Delivery Method: ☐ US Mail (Paper) ☐ CD ☐ Email (encrypted) File size limited -

Email Address: ____________________

Choosing to receive PHI by CD or Email is not secure and carries risk. I understand that email may be misdirected to recipients not listed on this form. By requesting either of these delivery methods, I accept this risk.

Dates of Treatment Requested: From ____ /____ /____ To ____ /____ /____

Purpose of Requested Information: ☐ Personal ☐ Continuation of Care ☐ Legal ☐ Insurance

☐ Other ____________________

I authorize the following PHI to be released:

☐ Entire Record	☐ Operative Report	☐ Lab Reports	☐ Radiology Reports
☐ Discharge Summary	☐ ER Record	☐ Cardiac Reports	☐ Clinic Notes
☐ Discharge Instructions	☐ History & Physical	☐ Obstetric Records	☐ Progress Notes
☐ Consultations	☐ Medication Records	☐ Pathology Reports	☐ Flow Sheets
☐ Therapy	☐ Plan of Care	☐ Assessments	☐ Other

This authorization will expire 180 days after the signature date on this form.

1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I can get a copy of this form if I request it, after I sign below.
6. 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.
7. If I have requested to receive health information in an electronic format, I acknowledge and accept the risks described above.

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 below:

AIDS/HIV Treatment	Mental Health Treatment	Drug or Alcohol Abuse Treatment
☐ YES Release	☐ YES Release	☐ YES Release
☐ NO Do not Release	☐ NO Do not Release	☐ NO Do not Release

By signing this form, I am authorizing the disclosure of my protected health information as stated.

Signature of Patient or Authorized Representative:	Date:
Print Name:	Relationship to Patient:
Witness Signature:	Telephone Consent Additional Witness Signature:

FREQUENTLY ASKED QUESTIONS ABOUT RELEASING MEDICAL INFORMATION

How can I get a copy of my hospital medical records?
Complete the attached authorization form and return to:

Holy Redeemer Hospital
Health Information Management Department
1648 Huntingdon Pike
Meadowbrook, PA 19046

The authorization form must be signed by the patient and is only good for six months from the date of signature.

If the patient is unable to sign, documentation must be provided indicating that you have the authority to sign on the patient's behalf.

A valid ID is required.

Can someone else pick up my medical records?
If you, the patient, specifies that person's name on the signed authorization form, records may be released.

We must be able to confirm your signature and the identity of the person picking up your medical records.

Is there a charge for copies of my medical record?
There may be a charge associated with copies of your records. This is authorized by a Pennsylvania Department of Health Notice regulated by Pennsylvania Act 26 which is updated every January. For specific information contact the Health Information Management department.

Note: There is no charge for records sent directly to your physician.

Can my family physician get copies of my medical record?
A courtesy copy of your discharge instructions are forwarded to your family physician if he/she is identified at the time of your admission to the hospital. If your family physician is the same as the attending physician who treated you while in the hospital, they have immediate access to your records.

Can I get a copy of my child's medical records?
As long as your child is under the age of 18, is not emancipated, or is not pregnant, you may be able to get a copy of these records.

Specific rules apply to the following circumstances:
Biological parents- married: Both mother and father have an equal right to their child's medical records.

Biological parents - never married: Mother has the ability to sign the release of information authorization form. If an Acknowledgement of Paternity form along with the birth certificate contains the Father's name, he has the authority to sign the release of information form as well.

Step-parents: A court order that permits the step-parents to sign for the release of the child's information is necessary.

Adoptive parents: As long as the biological parent's rights have been terminated in the process of adoption, adoptive parents may sign the release of information form.

Can I get the records of a deceased patient?
There are certain circumstances when records are provided; as long as you are the executor of the decedent's estate or the next of kin responsible for the disposition of the remains. There may be a charge for the cost of reproducing the copies as stated above.

Life insurance companies can obtain medical records for the purposes of paying out life insurance benefits as long as the request from the life insurance company includes a release of information authorization from the executor of the estate or the next of kin responsible for the disposition of the remains.

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