Redeemer Health

MRN:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be complete for all Authorizations		
Patient Name:	**Date of Birth:**	**Social Security No.:** *(last 4 digits)*
Street Address:	**City, State Zip Code:**	**Patient's Phone:**
Name of Facility/Person to Receive Records:		**Recipient's Phone:**
Recipient's Street Address:	**City, State Zip Code:**	**Recipient's Fax:**

This authorization will expire in 120 days from the date of signature, unless otherwise specified: (Fill in the Date or Event but not both.)**Date:** _____ **Event:** _____

I am requesting my PHI from: (Check the source of records being requested)

HOSPITAL MEDICAL RECORDS	LIFECARE	HOMECARE/HOSPICE	PHYSICIAN AMBULATORY SERVICES
☐ *INPATIENT HOSPITAL RECORDS* ☐ *AMBULATORY SURGERY CENTER* ☐ *OUTPATIENT* - LAB \ RADIOLOGY \ SURGERY \ EKG \ SLEEP LAB ☐*OTHER*_____	☐ *ST. JOSEPH MANOR* ☐ *LAFAYETTE*	☐ *(PA/NJ)*	☐ *PRIMARY CARE* ☐ *WOMEN'S HEALTH* ☐ *SPECIALTY PRACTICE*

Delivery Method: □ US Mail (Paper) □ CD (if available)

□ Email (encrypted) File size limited - Email Address: _____

Choosing to receive PHI by CD or Email carries risk. I understand that email or a CD may not be secure, and may be misdirected. By requesting either of these delivery methods, I accept this risk:_____(initial)

Purpose of Disclosure: □ Personal □ Continuity of Care/Medical Provider □ Legal □ Insurance/Disability

□ Other_____

Description of information to be disclosed

Is this request for psychotherapy notes? □Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. □ No, then you may check as many items below as you need.

	Entire Record		Operative Report		Radiology Reports \ Imaging		Clinic Notes
	Discharge Summary		ER Record		Cardiac Reports		Progress Notes
	Discharge Instructions		History & Physical		Obstetric Records		Flow Sheets
	Consultations		Medication Records		Lab/Pathology		POC (Point of Care)-*Lifecare*
	Physician Orders		Nursing Notes		Transfer forms		Itemized bill/billing invoices
	Therapy Notes		Plan of Care		Assessments		Other

I acknowledge that substance use/abuse, mental health, and/or HIV/AIDS health information will be released through this authorization unless otherwise indicated.

Do not release: ☐ **Drug/Alcohol** ☐ **HIV** ☐ **Mental Health**

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records, the confidentiality of which may be protected by federal and/or state law. If the records are so protected, federal or state regulations may prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by federal regulations. Federal regulation 42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records.

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

I understand:

1. Signing this authorization is voluntary, and I have the right to refuse to sign without it affecting my care.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time by sending a written notice to the appropriate entity at the address listed on the bottom of this form, 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, or you may contact Redeemer Health's Compliance Department at 521 Moredon Rd., Huntington Valley, PA 19006 or via e-mail at HRHSCompliance@redeemerhealth.org.
4. 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.
5. If this authorization includes mental health, substance use/abuse, genetics, or HIV/AIDS-related information, such information is subject to additional protections under federal and state law, and I expressly consent to its disclosure as described above.
6. Redeemer Health is not a Part 2 Program, and that my substance use disorder patient records originating from a Part 2 Program are protected under federal regulations 42 C.F.R. Part 2, and cannot be disclosed without my written consent.
7. The released records may contain information related to my reproductive health.
8. I may see and obtain a copy of the information to be released, for a reasonable copy fee, if I ask for it.
9. I may choose and have the right to have my records released directly to me so that I can review and inspect the records, for information I do not wish to be disclosed to a third party.
10. I can get a copy of this form if I request it, after I sign below.
11. 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.
12. If I have requested to receive health information in an electronic (Email/CD) format, I acknowledge and accept the risks described above.

Section B: I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient:	Date:
Signature of Authorized Representative: _____ ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____ **attach a copy of the appropriate legal document, which provides authority to act on Patient's behalf.*	Date:
Print Name of Patient/Authorized Representative:	

Return form to the appropriate Location (please address to 'Medical Records'):

HOSPITAL	LIFECARE	LIFECARE	HOMECARE/HOSPICE	PHYSICIAN & Ambulatory Services
Holy Redeemer Hospital **Attn: Medical Records**	**St. Joseph Manor** **Attn: Medical Records**	**Lafayette Redeemer** **Attn: Medical Records**	**Redeemer Health** **Attn: Medical Records**	**Attn: Medical Records**
1648 Huntingdon Pike Meadowbrook, PA 19046	**1616 Huntingdon Pike, Meadowbrook, PA 19046**	**8580 Verree Rd, Philadelphia, PA 19111**	**12265 Townsend Rd. Suite 400, Philadelphia, PA 19154**	**1648 Huntingdon Pike, Meadowbrook, PA 19046**
Fax: 215-938-3962	**Fax: 215-938-4071**	**Fax: 215-722-1026**	**Fax: 877-939-7102**	**Fax: 215-938-3962**