ROXBOROUGH MEMORIAL HOSPITAL

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AUTHORIZATION TO OBTAIN ____ OR RELEASE PATIENT HEALTH INFORMATION ____

I hear by authorize Roxborough Memorial Hospital to release/obtain (please specify above) the following information from the health records of:

PATIENT NAME: _____ **DOB:** _____ **SS#:** _____

ADDRESS: _____ **PHONE NO:** _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

___Patient Requests Access/Release of the following information: (Please include dates where appropriate)

Date(s) of Service _____

__ Emergency Room Record
__ Discharge Summary
__ Pathology Report
__ Out-Patient Psych Records
__ Face Sheet
__ Inpatient Record
__ Operative Report
__ Lab Report
__ Initial Evaluation
__ Consultation
__ Short Procedure Record
__ History & Physical
__ Radiology Report
__ Treatment Plan
__ Abstract of Record
__ Out-Patient Record
__ Progress Notes
__ Immunization Records
__ Psychiatric Evaluation
__ Billing Record

__ Other (Please Specify) _____

**INFORMATION IS TO BE RELEASED TO:
(Please check one)

**INFORMATION IS TO BE OBTAINED FROM:

NAME: _____ **PHONE NO:**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

FOR THE PURPOSE OF: _____

_____

This information has been disclosed to you from records protected by Federal Confidentiality (42 CFR Part 2) and PA law. The Federal and State law prohibit 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

___ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I permit the following information to be released:

___ BEHAVIORAL OR MENTAL HEALTH ___ HIV/AIDS ___ DRUG/ALCOHOL ___ GENETIC TESTING

PATIENT SIGNATURE: _____ DATE: _____

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AUTHORIZATION TO ACCESS/RELEASE
PATIENT HEALTH INFORMATION

***PLEASE COMPLETE OTHER SIDE

ROXBOROUGH MEMORIAL HOSPITAL

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AUTHORIZATION TO ACCESS/RELEASE PATIENT HEALTH INFORMATION

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

If I fail to specify an expiration date, event or condition, this authorization will expire in: _____(no more than 6 months.)

Request for Original Films or Pathology Specimens:

RELEASE OF ORIGINAL FILMS, PATHOLOGY SPECIMENS (indicate # and date of specimen(s) released):

FILM/SPECIMEN	DATE	FILM/SPECIMEN	DATE

FILM/SPECIMEN TAKEN BY/SENT TO:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

These films/specimens are legally the property of Roxborough Memorial Hospital and must be returned promptly after review.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If signed by Legal Representative, Relationship to Patient **Signature of Witness**

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INFORMATION RELEASED/OBTAINED VIA: __ PHONE __ US MAIL __ FAX (emergent patient care only) __ OTHER

MUST SEND A COPY OR SHOW A PICTURE IDENTIFICATION (I.E. DRIVER'S LICENSE, PICTURE ID) WITH THIS REQUEST.

Please return authorization to the Health Information Management Department (Medical Records); Roxborough Memorial Hospital, 5800 Ridge Avenue, 2nd Floor, Philadelphia, PA 19128

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in to assure treatment. I understand I may inspect or copy (with appropriate fees) the information used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director

***PLEASE COMPLETE OTHER SIDE