0048811

Patient Label (Name and Medical Record #)

ALBERT EINSTEIN HEALTHCARE NETWORK
BELMONT CENTER FOR COMPREHENSIVE TREATMENT
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ______________________________

Address: ______________________________
(City) (State) (Zip Code)

Social Security Number: _____/_____/_______ Date of Birth: ______________

Fees: I understand and agree that there are costs associated with this request in compliance with State Copying Laws.

Information to be disclosed: (Check all that apply)

_____	Face Sheet	_____	Discharge Summary	_____	Aftercare Plan	_____	History & Physical
_____	Interdisciplinary Assessment	_____	Treatment Plan (s)	_____	Progress Note (s)	_____	Consultation (s)
_____	Laboratory Result (s)	_____	HIV Result	_____	Radiology Result (s)	_____	Commitment Papers
_____	Other: ______________			_____	Telephone Conversation (s)		

I hereby authorize AEHN to release copies of **Psychiatric, Drug and Alcohol, HIV and Medical Information** from the health care record pertaining to my hospitalization of ______________ by mail, courier, telephone conversation, or facsimile transmittal to or from.

Send Information To:

Organization/Provider Name: ______________________________

Address: ______________________________

____
(City) (State) (Zip Code)

Telephone Number: ______________ Fax Number: ______________

Organization/Provider Name: ______________________________

Address: ______________________________

____
(City) (State) (Zip Code)

Telephone Number: ______________ Fax Number: ______________

These records are required for the purpose of: (Check at least one)

_____ Providing Information to support appropriateness of hospitalization and level of service to authorize payment
_____ Providing information to health care providers
_____ At the Request of the Individual _____ Legal Purposes _____ Social Security Disability _____ School
_____ Other: (Specify in Writing) ______________________________

This information has been provided to you from confidential records protected by the Pennsylvania Mental Health Procedures Act of 1976 (Title 55 Chapter 5100), the Pennsylvania Drug & Alcohol Control Act (which specifically limits the information relating to my drug and or alcohol abuse/ dependency to medical personnel for further treatment and government or other officials for the purpose of obtaining benefits), and the confidentiality of HIV related Information Act. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the Health Information Management Department.

This authorization is **valid for 90 days** from the date of my signature. I certify that this form has been fully explained to me and that I understand its contents, and have been offered a copy of this disclosure form. ☐ Accepted a copy ☐ Do not want a copy

______________________________ _____/_____/_______
(Signature of Patient 14 years of age or older) Date of Authorization

______________________________ _____/_____/_______
(Person authorized in Lieu of Patient) (Relationship) Date of Authorization

______________________________ _____/_____/_______
(Witnessed by) D A T E

This form must be dated within 90 days of receipt. *** See reverse side of form for verbal consent and refusal clause***

ALBERT EINSTEIN HEALTHCARE NETWORK
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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VERBAL CONSENT:

Verbal consent is acceptable if the patient is physically unable to provide a signature. Two witnesses attesting that the patient understood the nature of the disclosure/release and freely gave his/her consent must sign below.

PATIENT NAME: ______________________________

WITNESSED BY: ______________________________ **DATE:** ____/______/______
(TITLE OR RELATIONSHIP)

WITNESSED BY: ______________________________ **DATE:** ____/______/______
(TITLE OR RELATIONSHIP)

REFUSAL CLAUSE: (MUST BE A CURRENT INPATIENT)

I hereby acknowledge that I have been asked to sign the Authorization to Disclose Protected Health Information form on the reverse side of this form and HEREBY REFUSE PERMISSION. Therefore, no information shall be released to the parties identified unless otherwise required by law or court order, where permissible. Any information released shall be provided in accordance with applicable law.

PATIENT NAME: ______________________________ **DATE:** ____/______/______

WITNESSED BY: ______________________________ **DATE:** ____/______/______
(TITLE OR RELATIONSHIP)

Belmont Center for Comprehensive Treatment
4200 Monument Road
Philadelphia, PA 19131

(215) 581-5413 Health Information Management
(215) 581-5414 Correspondence Section

Philadelphia Center for Human Development
10360 Drummond Road
Philadelphia, PA 19154

(215) 632-6400 Main Telephone Number

Albert Einstein Medical Center
5501 Old York Road
Philadelphia, PA 19141

(215) 456-6800 Health Information Management
(215) 456-2368 Correspondence Section

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

If further disclosure is made, notice shall be sent to the appropriate HEALTH INFORMATION DEPARTMENT listed above

AEHN will act on this request for access/photocopying/accounting of disclosures/authorization to disclose no later than **30 days or (60 days for records stored off-site)** after receipt of your request, unless one 30-day extension has been requested and granted, in which case AEHN will notify you of this extension and provide you with the date by which we will complete your request.

If your request for photocopies of Protected Health Information is denied, you will be notified in writing, of the denial and the reason for it. You will also be provided a statement of any review rights you may have and with the description of how to register a complaint about the denial.

Date Received: ____________________

Date Information Released by Case Manager / Physician or HIM Department: ____________________

Information Released: ______________________________