(PLACE PATIENT ID LABEL HERE)

(ALL ENTRIES MUST HAVE DATE & TIME)

0003211

EINSTEIN HEALTHCARE NETWORK

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State ZIP

Home Phone: _____ Work Phone: _____

RELEASE OF INFORMATION TO:

Name/Organization: _____

Address: _____

City, State: _____ Zip Code: _____ Telephone #: _____ Fax #: _____

Are you requesting psychotherapy notes? ☐ Yes ☐ No If yes, you may only request psychotherapy notes on this authorization. You must submit a separate authorization for other items.

INFORMATION TO BE DISCLOSED COVERING THE FOLLOWING PERIOD(S): (Must be Specific)

Specify Dates of Treatment: _____ _____

_____ _____

PURPOSE OR NEED FOR THE DISCLOSURE IS:

☐ Continued Care ☐ Third Party/Insurance Review ☐ School Registration
☐ Legal Consultation ☐ Benefits Assignment ☐ Camp Registration
☐ Patient's Own Use ☐ Other: _____

INFORMATION TO BE RELEASED:

☐ Designated Record Set/Abstract ☐ Discharge/Clinical Summary ☐ Immunization Record
☐ Operative Procedure Report ☐ Consultation Report(s) ☐ History & Physical Report
☐ Laboratory Report ☐ Pathology Report ☐ Radiology Report
☐ Emergency Record ☐ Other: _____
☐ Entire Medical Record for Visit(s) specified above

EXPIRATION DATE: _____
Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, PL. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations,, Under the Mental Health Act this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication to the Einstein Healthcare Network and/or that my consent expires under the circumstance above. There is the potential that the information disclosed may be redisclosed by the recipient and no longer protected by law. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned by signing the authorization. A copy of this authorization and a notation concerning the persons or agencies to which this disclosure was made shall be included with the original health records.

I understand that any information disclosed in response to this request will not include information related to my treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse unless specifically checked below. An authorization for psychiatric care/treatment notes may not be combined with any other general release of information request.

☐ **AIDS/HIV Information** ☐ **Psychiatric Care/Treatment** ☐ **Treatment for Drug and Alcohol Use/Abuse**

_____	_____	_____	_____ ☐ AM ☐ PM
Patient's Signature	Patient's Printed Name	Date of Authorization	Time
_____	_____	_____	_____ ☐ AM ☐ PM
Signature of Parent / Legal Guardian / Legal Representative	Printed Name of Parent / Legal Guardian / Legal Representative	Date of Authorization	Time

_____
Relationship to Patient

_____	_____	_____	_____ ☐ AM ☐ PM
Witnessed By	Witness Printed Name	Date	Time

All Record Pickups will be held for 8 weeks only.