0003211

(PLACE PATIENT ID LABEL HERE)

EINSTEIN HEALTHCARE NETWORK

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name ______________________ Date of Birth ______________________

Address ______________________ City, State, Zip Code ______________________

Home Phone Number ______________________ Work Phone Number ______________________

RELEASE OF INFORMATION TO:

Name/Organization: ______________________

Address: ______________________

City, State: ______________________ Zip Code: __________ Telephone #: ______________ Fax #: ______________

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

INFORMATION TO BE RELEASED:

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

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, P.L. 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. I understand that once copies of my information are provided, EHN cannot prevent re-disclosure by the recipient.

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**

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 ☐ AM ☐ PM
Relationship to Patient			
Witnessed By	Witness Printed Name	Date	Time ☐ AM ☐ PM

All Record Pickups will be held for 8 weeks only.