

**Patient Examined at:**  Schuylkill Medical Center, East Norwegian St.  Schuylkill Medical Center, South Jackson St.

### AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

I hereby authorize  Schuylkill Medical Center, East Norwegian Street  Schuylkill Medical Center, South Jackson Street to  release or  obtain protected health information to/from:

\_\_\_\_\_  
\_\_\_\_\_

For the purpose of:

- |                                                                                          |                                                |
|------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Continuation of Medical Treatment                               | <input type="checkbox"/> Payment of Bill       |
| <input type="checkbox"/> Worker's Compensation                                           | <input type="checkbox"/> Legal Purposes        |
| <input type="checkbox"/> Insurance Purposes                                              | <input type="checkbox"/> Personal Access       |
| <input type="checkbox"/> At the request of the patient or patient's legal representative | <input type="checkbox"/> Other (specify) _____ |

The information to be released will cover the time period from \_\_\_\_\_ to \_\_\_\_\_

#### SPECIFIC INFORMATION TO BE RELEASED:

- |                                                |                                                 |                                                         |
|------------------------------------------------|-------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> History & Physical     | <input type="checkbox"/> Consultation Reports           |
| <input type="checkbox"/> Operation Reports     | <input type="checkbox"/> Physician Orders       | <input type="checkbox"/> Progress Notes                 |
| <input type="checkbox"/> Laboratory            | <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Radiology Reports/Films/Images |
| <input type="checkbox"/> Itemized Bills        | <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Cardiology Notes               |
| <input type="checkbox"/> Emergency Room Notes  | <input type="checkbox"/> Medication Records     | <input type="checkbox"/> Nursing Notes                  |
| <input type="checkbox"/> Other (Specify) _____ |                                                 |                                                         |

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I may revoke this authorization at any time by submitting a written notice, as described in the Notice of Privacy Practices. I understand that if I revoke the authorization it will not have any affect on any actions taken before the receipt of the revocation. I understand that this authorization will expire sixty days after the date of signature or automatically when the records requested on this authorization have been released. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it, except in any case in which re-disclosure is prohibited by state or federal law. I understand that I am entitled to a copy of this authorization.

#### SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity to release information related to the testing, diagnosis, and/or treatment for any of the following conditions, please initial in front of the section which describes the type of information to be released.

- \_\_\_\_\_  
Initial My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization.
- \_\_\_\_\_  
Initial My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted on the signed authorization.
- \_\_\_\_\_  
Initial My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

#### AUTHORIZATION SIGNATURES

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
(Parent/legal or personal representative)

Witness Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\*\*\*\*\*Copy of Completed Authorization Form Must Be Given To The Patient\*\*\*\*\*

## Schuylkill Medical Center

### Authorization to Release/Disclose Health Information

Form: 41-01  
Revisions: 5/09

Patient Identification