0003211

Einstein Healthcare Network
Authorization to Release Protected Health Information

Patient Label (Name and Medical Record #)

☐ EMCP ☐ EMCM ☐ EMCEP ☐ CtrOne ☐ GCHS
☐ MossRehab ☐ Belmont ☐ Willowcrest ☐ Other___________

Authorization to Release Protected Health Information

Patient's Name: ______________________________ Date of Birth: ____________

Address: ______________________________

Home Phone: ______________________ Work Phone: ______________________

Release Information To:

Name/Organization: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

Information to be disclosed covering the following period(s):

Specify Dates: __________ __________ __________ __________

Purpose or Need for the Disclosure Is:

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

Information To Be Released:

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

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

______________________________ Signature of Patient ______________ Date

______________________________ Signature of Parent/Legal Guardian/Legal Representative ______________ Date

______________________________ Witness ______________ Date

______________ HIM Staff Completing Request

☐ Pick-up ☐ Mail ☐ Fax ☐ Prepaid ☐ Messenger

All record pickups will be held for eight weeks only.

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