Penn Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Label Area

Patient Name (First, Middle, Last) | Date of Birth

Address | City/State/Zip Code | Telephone Number

I am requesting my protected health information (PHI) from ☐ All Penn Medicine Locations

☐ Hospital of the University of Pennsylvania ☐ Penn Presbyterian Medical Center ☐ Pennsylvania Hospital ☐ Penn Medicine at Home

☐ Chester County Hospital ☐ Lancaster General Health ☐ Penn Medicine Princeton Health

☐ CPUP/CCA Outpatient Practice(s) _____ ☐ Other _____

I request my PHI to be released to:

Name of Person/Entity: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Covering the period(s) of care (list applicable dates of treatment): _____ / _____ / _____ **to** _____ / _____ / _____

I authorize the following PHI to be released from my medical records:

☐ Discharge Summary ☐ Operative Report ☐ Lab Reports ☐ Radiology Reports ☐ Radiology Images

☐ Discharge Instructions ☐ ER Record ☐ EKG/ECG/Cardiac Tests ☐ History and Physical ☐ Clinic/Progress Notes

☐ Itemized Billing Record ☐ Consultations ☐ Medication Records ☐ Abstract (Significant Documents)

☐ Other Instructions: _____

Behavioral Health Visits.

I authorize the release of information from my behavioral health visits by checking "Yes" here and signing below: ☐ Yes ☐ No

Substance Use Disorder (SUD) Visits.

I authorize the release of information from my SUD visits by checking "Yes" here and signing below: ☐ Yes ☐ No

Other than the behavioral health and SUD visit information described above, I understand that **the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, HIV/AIDS, and substance use disorder** (for example, from primary care visits) and that by signing this authorization I am agreeing to the release of such information. I can choose and have the right to have my records released directly to me so that I can review and inspect the materials, including for sensitive information I do not wish to be disclosed to a third party.

Purpose of requesting information:

☐ **Legal** ☐ **Insurance** ☐ **Personal** ☐ **Continuation of Care** ☐ Other: _____

Delivery Method:

☐ **US Mail (Paper)** ☐ **CD** ☐ **Fax** ☐ **Email, file size limits apply, if requested please provide email address:** _____

Important: CD/discs of images are not encrypted and may be accessible to others. Email generally is not secure and often is misdirected. I am accepting these risks.

AUTHORIZATION

My authorization will automatically expire one hundred eighty (180) days after the date of signature. I may revoke this authorization at any time, but must do so in writing, and the revocation will not apply to information that has already been released. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.

Signature of Patient or Personal Representative | Print Name | Date | Time

Relationship of Personal Representative to Patient | Print Name | Date | Time

If Authorization is signed by someone other than the patient, please state reason: _____

If information about behavioral health visits is being released as authorized above, signature of hospital representative validating authorization required.

Signature of Hospital Representative | Print Name | Date | Time

Signature of Second Witness for Verbal Consent | Print Name | Date | Time

PLEASE READ THE FOLLOWING INSTRUCTIONS ON REVERSE

Label Area

Instructions for Completing the Authorization for Disclosure of Health Information

1. Please carefully read and complete all sections of the Authorization for Disclosure of Health Information.
2. The patient or legally authorized representative must sign and date the form. Generally, only a patient may authorize release of his/her medical information.
   Exceptions to the rule are as follows:
   - **a.** Authorization of minors – If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.
   - **b.** Emancipated minors – An emancipated minor is a minor who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize the release of their medical information.
   - **c.** A minor who has been diagnosed with a venereal disease, a substance use problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.
   - **d.** Authorization after death – An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains can authorize the release of medical information.
   - **e.** Authorization of the incompetent patient – If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.
   - **f.** Signature of Staff – The staff obtaining signature requirement applies only to the release of behavioral health care information as specifically authorized by the patient. The hospital or records management staff person obtaining this authorization of the patient or legally authorized representative (either in writing as witnessed, or by verbal confirmation of the written form) should sign, print name, date and time the form. A second witness is required to sign if the patient/patient representative consents verbally. Please have the witness sign, print their name and include the date and time.

Penn Medicine reserves the right to request proof of representation.

Any Ambulatory/Office Visit requests should be addressed to the individual Physician's Office.

The address to submit Inpatient, Emergency Department and Ambulatory Procedure/Short Procedure Unit record requests:

Hospital of the University of Pennsylvania (HUP)
3400 Spruce Street
Medical Records Department
1st Floor Founders
Philadelphia, PA 19104

Penn Presbyterian Medical Center (PPMC)
51 North 39th Street
Medical Records Department
Myrin Basement
Philadelphia, PA 19104

Pennsylvania Hospital (PAH)
800 Spruce Street
Medical Records Department
1st Floor Preston
Philadelphia, PA 19107

Chester County Hospital (CCH)
701 East Marshall Street
Medical Records Department
West Chester, PA 19380

Lancaster General Health (LGH)
555 N. Duke Street, 1st Floor
Medical Records Department
Lancaster, PA 17604

Penn Medicine Princeton Health (PMPH)
One Plainsboro Road
Medical Records Department
Plainsboro, NJ 08536

Please note:

1. Penn Medicine will charge for copying records in accordance with Pennsylvania, New Jersey and Delaware law, as applicable. Patient cost for Radiology images and reports will be free of charge.
2. Penn Medicine will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.
3. Penn Medicine will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information that is not maintained on site. If Penn Medicine is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
4. Penn Medicine may deny this request under limited circumstances as provided for under federal law. Penn Medicine will notify you if it denies your request to access or obtain a copy of the requested information. If Penn Medicine denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the Penn Medicine Chief Privacy Officer at the following address: Office of Audit, Compliance and Privacy, 3819 Chestnut Street, Suite 214, Philadelphia, PA 19104.
5. Records released may contain information and images created and prepared by third parties not under the control of Penn Medicine. Penn Medicine is not responsible for the content, accuracy or review of such records.
6. **Recipients of mental health or HIV/AIDS information may not re-disclose that information unless with written patient consent or as allowed by law. Federal regulation 42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records.**