0003211

(PLACE PATIENT ID LABEL HERE)

(ALL ENTRIES MUST HAVE DATE & TIME)

ALBERT 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 ☐ 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

Delivery Method Preferred: **Electronic Copy:** ☐ **Secure Web Portal** ☐ **CD**
Paper Copy: ☐ **Pick Up** ☐ **Mail**

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 Albert Einstein Healthcare Network and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, AEHN 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/treatment, treatment for drug/alcohol, *unless I specifically consent to release of this information by checking any or all the boxes below:*

☐ **AIDS/HIV Information** ☐ **Psychiatric Care/Treatment** ☐ **Treatment for Drug and Alcohol use/abuse**

_____ _____
Patient's Signature Date of Authorization/Time

_____ _____
Signature of Parent/Legal Guardian/Legal Representative Date of Authorization/Time

_____ _____
Witnessed By Date/Time

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

_____
HIM Staff Completing Request

0.00032-11 (Rev. 1/12)

All Record Pickups will be held for 8 weeks only.

Unapproved Abbreviations: AD, AS, AU, IU, MSO4, MS, MgSO4, OD, QD, QOD, TIW, U, μg