Penn Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

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

☐ Hospital of the University of Pennsylvania – 3400 Spruce Street, 1st Floor Founders, Philadelphia, PA 19104
☐ Penn Presbyterian Medical Center – 51 N. 39th Street, Myrin Basement, Philadelphia, PA 19104
☐ Pennsylvania Hospital – 8th and Spruce, 1st Floor Preston, Philadelphia, PA 19107
☐ Penn Chester County Hospital – 701 East Marshall Street, West Chester, PA 19380
☐ Penn Home Care & Hospice
☐ CPUP/CCA Outpatient Practice(s) _____ ☐ Other: _____

I request my PHI be released to:
Name of Person or Institution:_____ Address_____

City: _____ State: _____ Zip Code: _____ Fax (if Healthcare Provider):_____

Special Records: I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below:

AIDS/HIV Information	**Psychiatric Care/Treatment**	**Drug or Alcohol Abuse Treatment**
☐ Yes, disclose	☐ Yes, disclose	☐ Yes, disclose
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

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

☐ Discharge Summary	☐ Operative Report	☐ Lab Reports	☐ Radiology Images/Reports
☐ Discharge Instructions	☐ ER Record	☐ EKG/ECG Cardiac Tests	☐ Abstract (Significant Documents)
☐ History and Physical	☐ Progress Notes	☐ Clinic Notes	☐ Itemized Billing Record
☐ Consultations	☐ Medication Records	☐ Radiology Reports	

☐ Other Instructions: _____

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

Purpose of requested Information:
☐ **Legal**   ☐ **Insurance**
☐ **Personal**   ☐ **Continuation of Care**
☐ **Other**_____

Delivery Method:
☐ **US Mail (Paper)**   ☐ **Email (not secure) File size limits apply**
☐ **CD**

Important: I understand that the CD/disc of images are not encrypted and may be accessible to others if the CD/disc is lost or stolen. I also understand that unencrypted email is not secure – and therefore may be intercepted by others. I also understand that email may be misdirected and easily forwarded to unintended recipients. By choosing to receive my health information by CD/disc or via email, I am accepting these risks.

AUTHORIZATION

I hereby authorize Penn Medicine to disclose the health information as described above. I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form. I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. If I have requested to receive health information electronically, I acknowledge and accept the risks described above concerning unencrypted electronic formats. 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 describe above

Signature of Patient or Personal Representative	Print Name	Date	Time

Relationship of Personal Representative to Patient		Date	Time

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

If psychiatric care information 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

This information has been disclosed to you from records whose confidentially is protected by State statue. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

PLEASE READ THE FOLLOWING INSTRUCTIONS ON REVERSE

Instructions For Completing The Authorization For Disclosure of Health Information

1. Please 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 under the age of 18, who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.

   c. A minor who has been diagnosed with a venereal disease, a substance abuse 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 may give consent for 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 psychiatric 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.

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

Hospital of the University of Pennsylvania (HUP)	Penn Presbyterian Medical Center (PPMC)
3400 Spruce Street	Medical Records Department
Medical Records Department	51 North 39th Street
1st Floor Founders	Myrin Basement
Philadelphia, PA 19104	Philadelphia, PA 19104
Pennsylvania Hospital (PAH)	Chester County Hospital (CCH)
Medical Records Department	Medical Records Department
800 Spruce Street, Ground Floor	701 East Marshall Street
Philadelphia, PA 19107	West Chester, PA 19380

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

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:

   Penn Medicine
   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 control of Penn Medicine. Penn Medicine is not responsible for the content, accuracy or review of any such records.