Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Protected Health Information Authorization for Release, Use, and Disclosure

Mailing address: P.O. Box 16052, Reading, PA 19612

Located at: 420 South 5th Avenue, West Reading, PA 19611

Health Information Management - Telephone: 484-628-8252

Last Name _____ First Name _____ Date of Birth _____ MRN _____

Address _____ Phone _____ Email _____

I authorize _____ to release my Medical Records to: ☐ Me or ☐ Recipient:

Name of Authorized Person, Doctor, Hospital, Agency or Other _____ Phone _____

Address _____ Fax _____

ATTENTION PATIENT:
I understand and authorize the release of this information with the exceptions of: _____
If included in the medical record, this authorization includes the release of information protected by: Confidentiality of HIV-Related Information Act (AIDS, HIV-related information or testing), Mental Health Procedures Act (psychiatric disorders), Drug and Alcohol Abuse Control Act (drug and/or alcohol treatment) as permitted by law.

Information to be released: **Date(s) of Service**:_____

☐ Discharge Summary ☐ Operative Report ☐ PT/OT ☐ Radiology/Imaging Reports
☐ Emergency/Trauma Records ☐ Outpatient Clinic ☐ Radiology Images ☐ Review Records (by appointment)
☐ Labs ☐ Pathology Reports (not available through MyChart) ☐ Speech And Hearing
☐ Abstract of Medical records = H&P, Discharge Summary, Diagnostic Test Results, Problem List, Medications, Allergies and Procedure reports EKG's Labs
☐ Electronic Abstract = Discharge Summary, Diagnostic test Results, Problem List, Medication, Allergies and Procedure reports
☐ Other = _____
☐ Complete Medical Record ☐ Billing Record

Reason for Disclosure: ☐ Personal ☐ Further Medical Care ☐ Legal Investigation or Action ☐ Other: _____

☐ Out of Reading Hospital to: _____

I would like to receive this information VIA: ☐ Paper ☐ CD ☐ Secure Email ☐ MyChart Patient Portal ☐ Other:_____
CD #_____

I understand the following: I may revoke authorization in writing at anytime; this revocation will not apply to information that has already been released in response to this authorization. The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization. I have the right to inspect or copy the health information to be used or disclosed as permitted by law. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable). Reading Hospital may receive compensation for medical record copying in accordance with PA Law, 42 Pa. C.S. §6152. I understand that this consent will expire 90 days from the date below or upon my death, whichever occurs earlier.

Signature of Patient or Authorized Representative Date

Signature of Witness Date

Printed Name of Patient

Printed Name of Witness

Relationship to Patient

Title/Department

Important Information about Medical Records Requests

Requesting Your Records

The Records Release Center of our Health Information Management Department is available to assist you with obtaining copies of your medical records and radiology images. You may contact us by:

Telephone: 484-628-8252
Fax: 484-628-9777
Mail: Reading Hospital Records Center, PO Box 16052, Reading, PA 19612-6052

Picking Up Your Records

We highly recommend calling at least 24 hours in advance so that your records will be ready when you arrive.
Records can then be picked up in our: **Records Release Center**
Located at: 420 South 5th Avenue, West Reading, PA 19611
5th Avenue lobby of the Reading Hospital
Open Weekdays, 8 a.m. to 7 p.m.

To Access the Records Release Center

Use the 5th Avenue entrance to our West Reading Campus
Park in the patient drop-off spaces near the revolving door or use the free valet service for parking.
Enter through the revolving door.
Records Release Center is located to the left of the main Reception Desk in the lobby.

Identification Required.

Please bring a driver's license or other photo identification card. If you are picking up records for an adult 18 years of age and older, you must also have either: a note signed by the patient authorizing you to pick up his/her records OR Medical Power of Attorney documentation OR Legal Guardianship documentation.

Receiving Records Through MyChart Patient Portal

Receive in 3-5 days.
Records will be available to access and download for 14 days.
Medical Records from 2/2/13 to present can be provided through the MyChart Patient portal.
Radiology images are not available through MyChart Patient Portal

Other Services

To review your medical records, please call us for an appointment at 484-628-8252.

Charges

Per Pennsylvania Law, 42 PA. C.S. §6152, we may charge for copying records.
*Please do not send payment with your request, if payment is required you will receive a bill in the mail.