This information has been disclosed to you from records protected by Federal Confidentiality (42 CFR Part 2) and PA law. The Federal and State law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

AUTHORIZATION TO ACCESS/RELEASE PATIENT HEALTH INFORMATION

I hereby authorize Hahnemann University Hospital to release/obtain the following information from the health records of:

Patient Name: _____ Birth Date _____ MR# _____

Address: _____ Telephone No. _____

Email Address: _____ Last 4 SSN: _____

Covering the period(s) of hospitalization from:

Adm Date: _____ Discharge Date: _____ Output Date: _____ ER Date: _____

INFORMATION TO BE ACCESSED/RELEASED/OR DISCLOSED: (Check all that apply)

- ❑ Inpatient Record
- ❑ Emergency Room Record
- ❑ Short Procedure Record
- ❑ Discharge Summary
- ❑ Outpatient Psych Records
- ❑ Immunization Records
- ❑ Billing Record
- ❑ Pathology Report
- ❑ Operative Report
- ❑ Consultation Report
- ❑ Abstract of Record
- ❑ History & Physical
- ❑ Facesheet
- ❑ Other (Please Specify) _____
- ❑ Laboratory Reports
- ❑ Radiology Report
- ❑ Psychiatric Evaluation
- ❑ Treatment Plan
- ❑ Initial Evaluation
- ❑ Progress Notes

❑ Original films or pathology specimens (must complete reverse side of this form)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Please print below the name and address of the person or entity receiving this information:

Name: _____ Address: _____

City / State / Zip: _____ Phone: (_____) _____

PURPOSE OF THE DISCLOSURE: _____

_____

_____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire on: _____
No more than 6 months

Hahnemann University Hospital

AUTHORIZATION TO ACCESS/RELEASE PATIENT HEALTH INFORMATION

PATIENT ID

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy (with appropriate fees) the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director.

RELEASE OF ORIGINAL FILMS, PATHOLOGY SPECIMENS (indicate # and date of specimen released):

Film/Specimen	Date	Film/Specimen	Date

Film/Specimen to be taken by/sent to:

Name: _____
Telephone: _____
Address: _____

❑ Formalin Precautions discussed with patient/family.

These Films/Specimens are legally the property of Hahnemann University Hospital and must be returned promptly after review, if applicable.

Patient Signature	Date	Time
Witness Signature	Date	Time
Translator Signature (in necessary)	Date	Time

Send back to Tenet Health Records Request, 1150 Hayden Drive, Suite 112, Carrollton, Texas 75006 (Facsimile: (972) 416-2234).

For Internal Use Only: *The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.*

Print name of employee validating identity	*Telephone Extension*
Signature of employee validating identity	

PRINT SAVE AS EMAIL RESET

Hahnemann University Hospital

PATIENT ID

AUTHORIZATION TO ACCESS/RELEASE PATIENT HEALTH INFORMATION