Thomas Jefferson University

CONSENT TO RELEASE MEDICAL INFORMATION

THIS FORM EXPIRES ON: _____
(Insert date from Section II below)

COPY OF THIS CONSENT GIVEN TO PATIENT? ☐ Yes
☐ Patient Refused Copy

I. PATIENT IDENTIFICATION SECTION

Patient Name: _____

Date of Birth: _____ Date of Visit: _____

Address: _____

_____

II. WRITTEN CONSENT SECTION

I, _____ hereby consent to the
(Insert Patient Name)

release of the following information from my medical records by _____
(Insert Name and Address of Physician or Practice)

to _____ at the following address: _____
(Insert Name or Title of Individual or Organization Receiving Information)

_____

Specific Information to be Released:

_____

Specific Purpose of Release:

_____

If you do not sign this authorization, your treatment, payment for health care services, enrollment in health plans or eligibility for benefits will not be affected, unless:

(a) This authorization is for the use or disclosure of health information obtained in a research study. If you do not sign this authorization, you will be ineligible to participate in the research study for which this authorization is being requested.

(b) You have requested a service by Jefferson (for example, a physical examination, a letter about your medical problems) solely to provide the health information related to that service to a third party at your request.

This written consent is subject to revocation at any time by writing to the physician or practice which is to release the information except to the extent that this physician or practice has already acted in reliance on this consent. With the exception of mental health, HIV-related information or drug &/or alcohol abuse records, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. To revoke this consent, simply sign and date the revocation section on your copy of this form and return it to your physician's office or, if this authorization is for research, to the Principal Investigator (PI), the primary researcher conducting the study. If you do not have a copy, another copy will be provided. If not previously revoked, this consent will remain in force from

_____ to _____
(Today's date) (Specify date consent will expire, not to exceed 120 days, or specify illness or treatment at the end of which consent expire. **Insert expiration date at the top of this form.).**

This consent form has been fully explained to me and I understand its contents. I have been informed of my right under Pennsylvania law to inspect material to be released, subject to the limitations imposed by Pennsylvania regulations, 55 Pa. Stat. section 5100.33.

_____ _____
Signature of Patient Date

Signature of Legal Guardian, Next of Kin, Executor, Administrator, or other Legal Representative | Relationship | Date

Witness | Date

Reason consent is signed by person other than patient

III. VERBAL CONSENT

If the patient is physically unable to provide a signature, two responsible people must sign below.

The patient understands the nature of this release and freely gives his or her verbal consent, as witnessed by the following responsible individuals. The patient further understands that this verbal consent is subject to revocation at any time except to the extent that it has been relied upon. (In order to revoke this verbal consent, the patient must understand the nature of the revocation and freely give his or her verbal revocation, as verified in writing by two responsible witnesses.)

Witness 1 | Date

Witness 2 | Date

IV. STAFF IDENTIFICATION SECTION

Name of Person Obtaining Consent | Date

NOTICES TO ACCOMPANY RELEASE OF INFORMATION

Check Applicable Statement(s)

☐ **STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH RECORDS**

"This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains." 55Pa.Code section 5100.34(d).

☐ **STATEMENT TO ACCOMPANY DISCLOSURE OF CONFIDENTIAL HIV-RELATED INFORMATION**

"This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits 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 or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose." 35 Pa. Stat. section 7607(e).

☐ **STATEMENT TO ACCOMPANY RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS**

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules 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 or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

REVOCATION SECTION(to be completed and signed by the patient):

This consent expires on (00/00/00):_____ _____

Patient Signature