Jefferson®

4956NS.1016

Authorization to Release Health Information

Patient Name	Date of Birth

Full Address: Street/City/State/Zip

Telephone Number	Medical Record #	Social Security Number **(last 4 digits only)**:

Disclosed Information *(check all items to be released)* - COPYING FEE INFORMATION ON REVERSE

☐ **Summary of Records – Outpatient**
To be prepared by doctor after patient agrees to additional fees.

☐ **Abstract – Inpatient**
May include a discharge summary, discharge instructions, the history and physical, operative report, laboratory reports, radiology reports, consultations, EKG and other cardiology reports, neurological testing, and other pertinent testing or reports.

☐ **Other (please specify):** _____
For example: progress notes, history & physical, discharge summary, discharge instructions, operative report, ER record, imaging reports, lab/pathology reports, EKG/cardiology tests, immunizations, billing records, entire record, etc.

Covering the period(s) of treatment from _____ **to** _____

Physician Name or Department (for Outpatient Records): _____

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

Information Provided To

Name of Person or Institution	Telephone Number

Full Address: Street/City/State/Zip

Purpose/Use Of The Requested Information

☐ Personal use by patient ☐ Sharing with other health care providers ☐ Worker's Compensation ☐ Social Security
☐ Legal/Litigation ☐ Other (please describe): _____

Authorization Expires *(insert date or event)*

☐ 1 year from date of authorization ☐ Other Date or Event (please specify): _____
If no expiration date is designated this authorization will expire six (6) months from the signature date.

Authorization

I hereby authorize Thomas Jefferson University (TJU) and its controlled affiliates, including Jefferson University Physicians (JUP) and Thomas Jefferson University Hospitals, Inc. (TJUH), (collectively "Jefferson") to disclose the health information described above.

I understand the nature of this authorization and understand that it is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, except: (a) when this authorization is for the use or disclosure of health information obtained in a research study, or (b) when I have requested a service by Jefferson (for example, a medical second opinion) and the sole purpose of the service is to provide health information to a third party at my request.

I understand that I may revoke this authorization at any time by sending a written request to the address indicated on the back of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

X _____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Print Name **If Personal Representative, describe Relationship/ Authority to act for patient**

X _____ _____
Signature of staff person obtaining the consent (required for mental health records) **Date**

Records of deceased patients: If the requester is not the executor of the decedent's estate then the requester certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains.

Verbal Consent *(If the patient is physically unable to provide a signature. A verbal consent may be revoked by a verbal statement verified in writing by two witnesses.)*
I witness that the patient was physically unable to provide a signature, but that he/she understood the nature of this release and freely gave his/her oral authorization.

Witness Signature	Witness Printed Name	Date
Witness Signature	Witness Printed Name	Date

Please read instructions on reverse.

Instructions for Completing the Authorization for Disclosure of Health Information Form

1. **Please complete all sections of the Authorization for Disclosure of Health Information Form.**

2. **The patient or legally authorized representative must sign and date the form.**

   Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:
   - emancipated minors may sign this form (a patient age 16 or older who has left the parental household, supports him/herself financially, and lives independently);
   - minors who have married, been pregnant, or graduated from high school may also sign this form;
   - minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
   - minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.

3. **Please mail the completed form to:** **Thomas Jefferson University Hospitals, Inc.**
   Health Information Management Department
   111 South 11th Street, Gibbon Building, Suite 1950
   Philadelphia, PA 19107

Please Note

Jefferson will charge for copying records in accordance with PA Department of Health Notice regulated by Act 26 and the Health Insurance Portability and Accountability Act (45 CFR Parts 160-164). Cost for medical records vary based on the method of how records are produced and may also include: tax, postage and shipping.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Jefferson may deny this request under limited circumstances as provided for under federal law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.

Patients requesting mental health treatment records have the right to inspect the records to be released, subject to the limitations of 55 Pa. Stat. 5100.33.