Coordinated Health

Mailing Address: Medical Records Department, 3435 Winchester Road, 2nd Floor, Allentown, PA 18104

Medical Record Department Phone Number: 610-861-8080 x36099

Fax Number: 610-841-5834

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Phone: _____

Date Requested: _____

I authorize Coordinated Health to release healthcare information of the patient above to:

Name: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone:_____

I am requesting the following:

□ Disablity/FMLA Form □ Medical Record (paper) □ Medical Record (Electronic/CD)

I would like to receive the item above via:

□ Mail (to above address) □ Fax (to above number) □ Pick up at CH location: _____

Information to be released (for medical record requests only):

□ Entire Record			
□ Other (identify applicable boxes below):			
□ Lab Results	□ EKG Reports	□ Imaging Reports (x-ray, MRI, etc.)	□ Studies/Films (x-ray, MRI, etc.)
□ Office Visit Notes of Physician(s) – please specify: _____		□ Operative Reports by Physician(s) – please specify: _____	
□ Records of Specialty Line or location (Rehab/PT, CHHA, TCC, CHOH, etc.) –please specify: _____			
□ Other – please specify: _____			

Records are requested for the purpose of:

□ Personal use □ Legal □ Second opinion □ Other:_____

Approximate date of records you are requesting: _____

Attention patient: If applicable, please complete this section:

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/ HIV, psychiatric illness or drug/alcohol abuse. Please check the appropriate boxes to indicate understanding:

-AIDS/HIV related information	□ No, do **NOT** disclose	□ Yes, disclose*
-Mental Health information(Excludes psychotherapy notes, separate consent required)	□ No, do **NOT** disclose	□ Yes, disclose
-Drug/alcohol information	□ No, do **NOT** disclose	□ Yes, disclose

*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.

I hereby authorize Coordinated Health and its entities to disclose the health information as described above. This authorization is valid for 18 months from the date of signature of this request. I understand that: 1) this authorization may be revoked by me at any time by written notification to this facility, except to the extent that action has been taken in reliance upon this authorization; 2) Information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule; 3) Coordinated Health may not condition my treatment based upon whether or not I sign this authorization; **4) I understand that I will receive a copy of this authorization.** Please be aware that health care facilities are authorized by state & federal law to charge for the reproduction of medical records and that charges may be associated with this request. Requestors will be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Patient Signature: _____ Date:_____

Authorized Representative Signature: _____ Date:_____

□ Parent/Legal Guardian □ Power of Attorney □ Next of Kin of Deceased □ Estate Executor