

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Previous Name: _____

Address: _____ Date of Birth: _____

Date records needed by: _____ Phone: _____

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:

- Disability/FMLA Form Medical Record (paper) Medical Record (Electronic/CD-not encrypted)

I would like to receive the item above via:

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

Records are requested for the purpose of:

- Personal use Legal 2nd opinion/Medical Care Other: _____

Location of facility for records requested:

- CH Allentown Hospital CH Bethlehem Hospital Other CH facility _____

This authorization is limited to the following dates of treatment/service:

FROM _____ TO _____ (Dates MUST be filled in)

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

<input type="checkbox"/> Record summary*	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Imaging Reports (x-ray, MRI, etc.)	<input type="checkbox"/> Imaging films on CD (Note: CD's are not encrypted)
<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> EKG, EEG, Stress test	
<input type="checkbox"/> Gynecological Records	<input type="checkbox"/> Therapy Notes (PT/OT)	<input type="checkbox"/> Entire Record	
<input type="checkbox"/> Exception: I do not give permission to release (specify): _____			

*Record Summary includes key documents, such as: history and physical, recent test results, operative reports, discharge summaries, consultations, problem list, medication list, and recent office visits routinely provided to physicians for continuing care. Typically includes most recent 2 years of records.

Attention patient: 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:

<input type="checkbox"/> -AIDS/HIV related information	<input type="checkbox"/> No, do NOT disclose	<input type="checkbox"/> Yes, disclose
<input type="checkbox"/> -Mental Health information(<i>Excludes psychotherapy notes, separate consent required</i>)	<input type="checkbox"/> No, do NOT disclose	<input type="checkbox"/> Yes, disclose
<input type="checkbox"/> -Drug/alcohol information	<input type="checkbox"/> No, do NOT disclose	<input type="checkbox"/> Yes, disclose

I hereby authorize Coordinated Health and its entities to disclose the health information as described above. This authorization is valid for 6 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

Attached is a copy of the appropriate legal document, which proves authority to act on behalf of the patient.

This form must be completed in its entirety in order for it to be valid. Invalid forms will not be processed