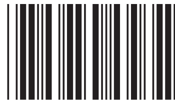
Lehigh Valley Health Network



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1: Patient Information **For timely processing, please PRINT clearly**

PATIENT NAME		SOCIAL SECURITY NO. (last 4 digits) XXX-XX-____________	DATE OF BIRTH
ADDRESS	CITY	STATE	TELEPHONE NO

Section 2: Location(s) of Care

Hospital / ASC	☐ 17th & Chew ☐ Muhlenberg ☐ Cedar Crest ☐ Hecktown Oaks ☐ Hazleton ☐ Pocono ☐ Schuylkill ☐ Coordinated Bethlehem ☐ Coordinated Allentown ☐ Coordinated East Stroudsburg Ambulatory Surgery Center ☐ Coordinated Phillipsburg Ambulatory Surgery Center Hospital Outpatient Department: ___________________________ (please specify)
Practice / Provider	☐ Lehigh Valley Physician Group ☐ Valley Health Partners ☐ Coordinated Health Providers Name of Practices or Providers ___________________________ Address ___________________________ City/State Phone ___________________________

Section 3: Release Records To:

I consent to and authorize the release information from my medical record from the above location to:	
Name of Doctor/Hospital/Person/Other/Self	
Address:	Fax#:
For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance ☐ Lay Caregiver ☐ Legal Purposes ☐ Personal Use ☐ Other: ___________________________	

Information disclosed pursuant to this authorization may be submitted to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Method of Sending Records:

☐ Secure email: ___________________________

☐ Fax: ___________________________

☐ Mailing address: ___________________________

Section 5: Specific Information To Be Released/Dates of Service

The information to be released will cover the time period from___________________________ to ___________________________

☐ Record Summary*	☐ Discharge Summary	☐ Radiology/Imaging films on CD
☐ Discharge Instructions (AVS)	☐ Consultation Reports	☐ Photographs
☐ Emergency Room Record	☐ Lab Results	☐ Physician Orders
☐ Office Notes/Visit Notes	☐ X-ray/Other Imaging Reports	☐ Therapy Notes (PT/OT)
☐ Immunizations	☐ EKG, EEG, Stress Tests	
☐ History & Physical (H&P)	☐ Other (specify):	
☐ Entire Record	☐ EXCEPTION: I do not give permission to release (specify): ___________________________	

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

Section 6: Special Authorizations for HIV, Mental Health, Drug and Alcohol Records

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 Care and Treatment, Treatment for Drug and Alcohol Abuse. Please check the appropriate box(es) and initial below indicating understanding.

☐ AIDS/HIV Related Information (Confidentiality of HIV-Related Information Act, PA Law Act 148)

☐ No, do not release ☐ Yes, release Initials ______________

☐ Psychiatric or psychological information (PA Mental Health Procedure Act)

☐ No, do not release ☐ Yes, release Initials ______________

☐ Drug or alcohol information (Confidential Alcohol and Drug Abuse Patient Information, 42 C.F.R. Part II)

☐ No, do not release ☐ Yes, release Initials ______________

Section 7: Authorization Signatures

This authorization is valid for 6 months from the date of signature on this request. I understand that this authorization may be revoked by me at any time by written notification to this facility. I understand that genetic information may be released as part of my health information. If this request for medical records has already been completed, the authorization will remain on file. In addition, in order to process this request for reproduction of medical record information on a timely basis, Lehigh Valley Health Network may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I have the right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Patient Signature____ Date Signed__________________________

Printed Name____

Signature of Authorized Representative:__________________________________ Date Signed__________________________

Printed Name of Authorized Representative:____

Relationship: ☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

Records of deceased patients: Must provide a copy of the Letter of Administration from the Court naming the personal representative. If not available, alternatively supply a copy of the death certificate which names the next of kin. (PA Code 115.29)

Health care facilities are authorized in Pennsylvania State & Government Regulations to charge for this reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Section 8: Contact Information, Mailing/Faxing Information

Send this completed authorization form with any appropriate legal documentation, if applicable to one or more of the following locations, based on where the patient received their care:

Facility Name:	Mail to:	Or Fax to:	Or E-mail to:	Contact us by phone:
Lehigh Valley Hospital – Cedar Crest/Muhlenberg/ 17th & Chew/Hecktown Oaks	HIM Cedar Crest Blvd & I-78 PO Box 689 Allentown, PA 18105-1556	610-402-5823	ROIMack@lvhn.org	610-402-8240
Lehigh Valley Hospital – Hazleton	HIM 700 E. Broad St. Hazleton, PA 18201	570-501-4930	ROIHazleton@lvhn.org	570-501-4131
Lehigh Valley Hospital – Pocono	HIM 206 E. Brown St. East Stroudsburg, PA 18301-3006	570-476-3709	ROIPocono@lvhn.org	570-476-3388
Lehigh Valley Hospital – Schuylkill	HIM 700 E. Norwegian St. Pottsville, PA 17901-2710	570-621-4719	ROISchuylkill@lvhn.org	570-621-4562
LVH Coordinated Health	HIM 3435 Winchester Rd., 2nd Floor Allentown, PA 18104	610-841-5834	LVH-CH_ROI@lvhn.org	484-884-8557
LVPG and VHP Practices/Providers	Please send your completed authorization directly to your physician practice. For a listing of LVPG Providers and locations please go to www.lvhn.org and select Find a Doctor			