Must be completed per practice

NAME OF PRACTICE HERE

595 West State Street Doylestown, PA 18901

Pick Up Date:

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Patient’s Name: Date of Birth: Address: Phone Number: Last 4 Digits of SS #: MR #: Release Records to:

Dates of Information to be released: Entire Record ECG/Cardiology Testing Results Medication List Consults ER Record Progress Notes Discharge Summary H&P Radiology Results Discharge Instructions Lab Results

Other:

**Advised of release requirements:** Photo ID Signed authorization

**These Records are needed: For personal use For continuation of care.**

**I** **understand:**

a. My medical record may contain information of a sensitive or extremely private nature, including, but not limited to a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.

b. I or my representative may revoke or modify this authorization at any time by writing to HIS of Doylestown Hospital except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking will only prevent future disclosure.

c. The hospital will not condition treatment, payment, enrollment or eligibility on the provisions of this authorization. d. Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be

protected by federal privacy regulations.

e. I understand that I cannot be compelled to authorize release of any of my medical records.

This authorization expires on: This authorization has no expiration date.

Patient signature Date

If person signing is someone other than patient:

Signature Date

Print Name

Relationship to patient and authority to sign (i.e. legal guardian, Power of Attorney)

**THIS FORM IS TO BE KEPT AS A PART OF THE PATIENT PERMANENT RECORD**

Photo ID type and #:

 Signature of Employee: