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# Main Line HealthCare

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*Main Line HealthCare has implemented an electronic medical record system into all its practices. Healthcare professionals involved in your care will have confidential access to your complete medical record for treatment, payment or healthcare operations as described in the Notice of Privacy Practices. The Notice of Privacy Practices is available on the Main Line Health website at [www.mainlinehealth.org](http://www.mainlinehealth.org). Other than healthcare professionals, we are not allowed to share health care information to anyone unless you give us the written consent to do so.*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**1. By filling out the information below, I hereby authorize the disclosure of my protected health information (or that of my child) including results, prescriptions and HIV/AIDS related information, if any, as well as appointments to be shared with the persons listed below.**

(Name) \_\_\_\_\_ Relationship \_\_\_\_\_

(Name) \_\_\_\_\_ Relationship \_\_\_\_\_

(Name) \_\_\_\_\_ Relationship \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**2. By signing below, I hereby authorize the practice to leave my protected health information (or that of my child) including results, prescriptions and appointments on my answering machine/voicemail at the numbers given below.**

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Number \_\_\_\_\_ Secondary Number \_\_\_\_\_

*Note: Main Line Healthcare authorizes faxing for transmitting medical information when a legitimate medical emergency arises and the information is required to treat the patient. Faxing of medical records for purpose other than patient care is strictly prohibited.*

**THIS FORM IS VALID FOR 6 MONTHS FROM THE DATE IT IS SIGNED.**