# INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM

1. Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion.

2. The patient or legally authorized representative (see #7 below) must sign and date the form.

3. Please mail the form to the appropriate facility to the attention of the Office Manager. **(Electronic copies cannot be accepted).**

4. Records will be mailed directly to the party listed as the recipient on the authorization form. We do not fax records to recipients unless needed for emergent patient care by another healthcare provider.

5. If the records are needed for continuing care purposes and are mailed directly to a physician or other healthcare facility, the records will be mailed free of charge.

6. Records for all other purposes are subject to copying charges in accordance with PA State Law. An invoice will be mailed to you and payment will be expected prior to the records being copied and mailed.

7. The following is a list of persons authorized to sign the disclosure of health information form:
   - If the patient is 18 years of age or older and is competent, then the patient must sign. No one else is authorized to sign.
   - Emancipated minors (*see definition below) are authorized to sign on their own behalf.
   - Minors are authorized to sign on their own behalf if they have been diagnosed with a venereal disease, treated for substance abuse or were treated to determine pregnancy.
   - If the patient is 14 years of age or older and received mental health treatment, the patient must personally sign.
   - If the patient is a minor (under 18 years of age) or under 14 years of age and received mental health treatment, then the parent or legal guardian must sign.
   - If the patient is over 18 years of age and is incompetent, then the legal representative must sign and provide proof of legal representation. (e.g. a photocopy of power of attorney documents or other legal documents).
   - If the patient is deceased, the executor may sign the authorization. In the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for release of information. If the patient is physically disabled, and unable to sign, a verbal consent may be accepted from the patient provided it is witnessed by two parties and is accompanied by the following statement:

     "We, the undersigned, certify that _____was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent."

*Definition:
Emancipated Minor: a minor age 16 or older who has left the parental household and established himself as a separate entity. A minor who is married, is or has been pregnant or who is a high school graduate is also considered emancipated. Emancipated minors can consent to their own treatment and the authorization for release of medical information.

Please contact your Main Line HealthCare Practice if you have additional questions or need further assistance.

(Rev. 2 16)

Main Line HealthCare
Physician Network

# Authorization for Disclosure of Health Information

I hereby authorize _____to release medical information from the records of:
(Name of Practice or Physician)

Patient Name: _____DOB: _____ Last 4 digits of SS#_____

Dates of Service From _______________ To _______________

Information to be disclosed - check all applicable items to be released. For a complete chart copy, place a check in all boxes.

| | | |
|---|---|---|
| ☐ Office Notes | ☐ Radiology Reports | ☐ Medication Records |
| ☐ Procedure Notes | ☐ Lab/Pathology Reports | ☐ Physical Therapy/Occupational Therapy Notes |
| ☐ Consultations | ☐ EEG/ECG Reports | |

☐ Other (please specify):_____

I understand that any information released pursuant to this request will not include any information related to my treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse unless specifically checked below.

☐ AIDS/HIV ☐ Psychiatric Care/Psychological Assessment ☐ Treatment for Drug or Alcohol use/abuse

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician, and I agree to pay such charges.

This information is to be disclosed to:

Name of Person or Institution: _____

Address: _____

City/State/Zip Code: _____ Phone # (for questions):_____

For the purpose of (required): _____

I understand that there is a potential that the information may be re-disclosed by the recipient of the information and that the recipient may not be required to comply with the Privacy Rule.

_____ _____ _____
(Signature of patient or personal representative) (Relationship to Patient) (Date)

_____ _____
(Signature of Witness) (Date)

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**Verbal Release of Mental Health Information:**
Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

_____ _____ _____ _____
(Witness) (Date) (Witness) (Date)

(Rev. 2/16)