Main Line HealthCare
Physician Network

Authorization for Release of Health Information

I hereby authorize _____to release medical information from the records of:
(Name of Institution)

Patient Name:_____D.O.B.: _____SS#:_____

Covering the period(s) of care (list applicable dates of treatment):_____

Information to be disclosed (check all applicable items to be released; for a complete chart copy, check all boxes)

- ☐ Progress Notes
- ☐ Medication Records
- ☐ Xray Reports
- ☐ ER Record
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ Consultations
- ☐ EKG/ECG Tests
- ☐ Operative Report
- ☐ Therapy Notes
- ☐ Other (please specify):_____

I understand that this will include information relating to (check if applicable to the patient's records):

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

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 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.

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

_____ _____
(Signature of Witness) (Date)

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)

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 "Health Information Management Department". The address for each hospital is listed at the top of the authorization form. (electronic copies will not 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.
   - If the patient is 14 years of age or older and was treated for a psychiatric admission, then the patient must sign.
   - If the patient is a minor (under 18 years of age) or under 14 years of age for psychiatric admission, 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 surviving spouse or other legal representative must sign and provide proof of legal representation (e.g. a photocopy of executor documentation, power of attorney, etc.).

Please contact the Office Manager of the practice if you have additional questions or need further assistance.