Main Line HealthCare
Physician Network

This form for Care Everywhere

Main Line Health

Authorization to Disclose Protected Health Information (PHI)

Patient name: _____

Date of birth: _____

Patient MRN: _____

I authorize Main Line Health to disclose my medical information electronically to all providers and organizations (and their staff) involved in my treatment or care for the purpose of my medical evaluation and treatment.

I understand that the medical information covered by this authorization includes **all information** in my medical record, including information relating to **the diagnosis and treatment of alcohol and drug abuse, psychiatric and mental health, HIV/AIDS, reproductive health including sexually transmitted diseases and genetic information**. The authorization covers any records available at the time they are requested and includes records that may be created after this authorization was signed.

This authorization becomes effective the date you sign it and remains effective for three hundred sixty five (365) days, unless you revoke it as described below.

I understand that I may refuse to sign this authorization and that no Main Line Health provider may condition treatment on my decision to sign authorization.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present or send my written revocation to the Health Information Management Department at 1991 Sproul Road, Suite 900, Broomall, Pa, 19008. I understand that revocation will not apply to information that has already been released in reliance on this authorization, nor to our continued ability to share your medical information for treatment purposes with your other healthcare providers through existing mechanisms such as telephone calls, faxes, mail and other electronic methods.

I understand that I have the right to receive a copy of this authorization.

By signing below, I authorize Main Line Health to release electronically my electronic medical record to all health care providers and their staff who are specified in this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship of Personal Representative to the Patient