AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION[1]

Physicians Care Surgical Hospital

454 Enterprise Drive Royersford, PA 19468

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

CITY/STATE/ZIP _____

PHONE # (provide direct # where you can be reached regarding this form or where a voicemail message may be left for you)

Home_____ Cell/other_____

Disclosure of protected health information is made at my request for:

☐ Change of Insurance ☐ Referral ☐ Other_____

☐ Change of Physician ☐ Personal health records

Records to be disclosed: DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED/CHECK ALL THAT APPLY:

☐ All Records* ☐ Records from (date) _____to (date)_____

☐ Discharge Summary ☐ Lab, x-rays and diagnostic tests only

☐ Operative or procedure report ☐ Nursing notes

☐ Anesthesia or other provider notes—specify ☐ Billing records only

☐ Physician History/Physical/orders, progress notes ☐ Other--must provide specific information _____

_____

**"All records" means all protected health information in a designated record set, which may include, but is not limited to, patient family histories, genetic information, inpatient/outpatient records, medical, dental, pharmaceuticals (medications), hospital, physician or other healthcare providers' records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices for services, and information from all other health care providers used for your care and treatment in the hospital or facility). If you received psychiatric or psychotherapy services, alcohol/chemical substance abuse treatment or treatment for HIV/AIDS which are federally protected as confidential, those records will be included unless you specifically exclude them in writing prior to disclosure.

Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

☐ **The facility/hospital named above**

☐ Other _____

Persons, facility, or class of persons who are authorized to receive the records/information:

Physician/hospital/other healthcare provider name_____

Attorney/law firm_____ N/A ☐

Address_____

City/State Zip_____

Phone #_____

Please complete more than one form if multiple disclosures to multiple providers are requested.

I authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by his form. I also understand that the hospital/facility will not condition treatment, payment, enrollment or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I also permit disclosure of information upon presentation of a use of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event or condition_____. If I fail to specific an expiration date, event or condition, this authorization will expire 1 (one) year from date signed.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____

Signature of Patient (or Patient's Personal Representative, if applicable) **Date of Signature**

Personal Representative's Relationship/Capacity to Patient:_____

Printed Name of Personal Representative: _____

Printed address & telephone number of Personal Representative: _____