



GOOD SHEPHERD
PENN PARTNERS

PENN THERAPY
& FITNESS

Label Area

**AUTHORIZATION TO RELEASE
HEALTH INFORMATION**

1. _____
Name of Patient Birth Date Phone Number

Street Address City, State, Zip

2. AUTHORIZES:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

3. RELEASE PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

4. INFORMATION TO BE RELEASED:
____ Entire Record ___ Therapy Initial Evaluation(s), Progress Note(s), Discharge Summary(s)
____ Physical Therapy ___ Other _____
____ Occupational Therapy
____ Speech Therapy

For the following dates: _____

In compliance with the Pennsylvania Mental Health Procedures Act:
____ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above,
____ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.



Date _____

5. PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Other (Specify) _____ |

6. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. Your Rights with respect to This Authorization:

- **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.
- **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of Health Information Management at (610) 776-3513. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following date(s) _____ or event(s) (specified event) _____

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient: _____ **Date:** _____ **Time:** _____

(If signed by person other than patient, state relationship and authority to do so).

Patient is: Minor Incompetent Disabled Deceased
Legal Authority: Custodian parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Healthcare Authorized Legal Representative

Signature of Witness: _____ **Date:** _____ **Time:** _____

Signature of Witness: _____ **Date:** _____ **Time:** _____

DO NOT USE UNAPPROVED ABBREVIATIONS