



Authorization to Release Health Information

Patient Name		Date of Birth
Full Address: Street/City/State/Zip		
Telephone Number	Medical Record #	Social Security Number (last 4 digits only):
Disclosed Information (<i>check all items to be released</i>) - COPYING FEE INFORMATION ON REVERSE <input type="checkbox"/> Summary of Records – Outpatient <i>To be prepared by doctor after patient agrees to additional fees.</i> <input type="checkbox"/> Abstract – Inpatient <i>May include a discharge summary, discharge instructions, the history and physical, operative report, laboratory reports, radiology reports, consultations, EKG and other cardiology reports, neurological testing, and other pertinent testing or reports.</i> <input type="checkbox"/> Other (please specify): _____ <i>For example: progress notes, history & physical, discharge summary, discharge instructions, operative report, ER record, imaging reports, lab/pathology reports, EKG/cardiology tests, immunizations, billing records, entire record, etc.</i>		
Covering the period(s) of treatment from _____ to _____ Physician Name or Department (for Outpatient Records): _____		
AIDS/HIV Information <input type="checkbox"/> Yes, disclose <input type="checkbox"/> No, do not disclose	Psychiatric Care/Treatment <input type="checkbox"/> Yes, disclose <input type="checkbox"/> No, do not disclose	Treatment for Drug or Alcohol use/abuse <input type="checkbox"/> Yes, disclose <input type="checkbox"/> No, do not disclose
Information Provided To Name of Person or Institution _____ Telephone Number _____ Full Address: Street/City/State/Zip _____		
Purpose/Use Of The Requested Information <input type="checkbox"/> Personal use by patient <input type="checkbox"/> Sharing with other health care providers <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Social Security <input type="checkbox"/> Legal/Litigation <input type="checkbox"/> Other (please describe): _____		
Authorization Expires (<i>insert date or event</i>) <input type="checkbox"/> 1 year from date of authorization <input type="checkbox"/> Other Date or Event (please specify): _____ If no expiration date is designated this authorization will expire six (6) months from the signature date.		
Authorization I hereby authorize Thomas Jefferson University (TJU) and its controlled affiliates, including Jefferson University Physicians (JUP) and Thomas Jefferson University Hospitals, Inc. (TJUH), (collectively "Jefferson") to disclose the health information described above. I understand the nature of this authorization and understand that it is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, except: (a) when this authorization is for the use or disclosure of health information obtained in a research study, or (b) when I have requested a service by Jefferson (for example, a medical second opinion) and the sole purpose of the service is to provide health information to a third party at my request. I understand that I may revoke this authorization at any time by sending a written request to the address indicated on the back of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.		
X _____ Signature of Patient or Personal Representative		_____ Date
_____ Print Name		_____ If Personal Representative, describe Relationship/ Authority to act for patient
X _____ Signature of staff person obtaining the consent (required for mental health records)		_____ Date
Records of deceased patients: If the requester is not the executor of the decedent's estate then the requester certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains.		
Verbal Consent (<i>If the patient is physically unable to provide a signature. A verbal consent may be revoked by a verbal statement verified in writing by two witnesses.</i>) I witness that the patient was physically unable to provide a signature, but that he/she understood the nature of this release and freely gave his/her oral authorization.		
_____ Witness Signature	_____ Witness Printed Name	_____ Date
_____ Witness Signature	_____ Witness Printed Name	_____ Date

Instructions for Completing the Authorization for Disclosure of Health Information Form

1. Please complete all sections of the Authorization for Disclosure of Health Information Form.
2. The patient or legally authorized representative must sign and date the form.

Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:

- emancipated minors may sign this form (a patient age 16 or older who has left the parental household, supports him/herself financially, and lives independently);
- minors who have married, been pregnant, or graduated from high school may also sign this form;
- minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
- minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.

3. Please mail the completed form to: **Thomas Jefferson University Hospitals, Inc.
Health Information Management Department
111 South 11th Street, Gibbon Building, Suite 1950
Philadelphia, PA 19107**

Please Note

Jefferson will charge for copying records in accordance with PA Department of Health Notice regulated by Act 26 and the Health Insurance Portability and Accountability Act (45 CFR Parts 160-164). Cost for medical records vary based on the method of how records are produced and may also include: tax, postage and shipping.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Jefferson may deny this request under limited circumstances as provided for under federal law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.

Patients requesting mental health treatment records have the right to inspect the records to be released, subject to the limitations of 55 Pa. Stat. 5100.33.