Abington Memorial Hospital
1200 Old York Rd., Abington, PA 19001

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

_____ ____/____/_____
Patient's Name (Please Print) Date of Birth

_____ (____) _____-_____
Address: (Street, City, State) Phone (Area Code and Number)

I THE UNDERSIGNED AUTHORIZE **ABINGTON MEMORIAL HOSPITAL (AMH)** THE USE/DISCLOSURE OF HEALTH INFORMATION PERTAINING TO THE PATIENT NAMED ABOVE.

I FURTHER AUTHORIZE THE USE/DISCLOSURE OF THE ABOVE NAMED PATIENT'S HEALTH INFORMATION TO THE FOLLOWING PERSON(S) AND/OR ENTITY.

From:	To:
Please Print Name of Individual or Entity	Please Print Name of Individual or Entity
Address: (Street Name and Number)	Address: (Street Name and Number)
Address: (City, State and Zip Code)	Address: (City, State and Zip Code)

I ASK THAT ONLY THE FOLLOWING HEALTH INFORMATION BE USED OR DISCLOSED BY AMH.

Please describe the health information for the above named Patient to be used or disclosed (eg., medical records etc.)

I REQUEST THE USE AND/OR DISCLOSURE OF THE ABOVE NAMED PATIENT'S HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

If Patient is requestor please write "at the request of the Patient"

I understand that if the person or entity that receives my health information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. (Please see Federal and State law prohibitions on redisclosure on reverse side of this form).

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

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I understand that I may revoke this authorization in writing at any time by submitting a written request to the AMH Patient Relations Department except to the extent that action has been taken in reliance on this authorization.

This authorization is valid from: ____/____/_____ to: ____/____/_____
Please fill in dates

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
I authorize AMH to use or disclose the health information noted above including any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition(s), including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information; (in accordance with Federal confidentiality rules (42 CFR Part 2), State Mental Health Procedures Act and Act 148).

If there are any limitations to this list of health information to be used and/or disclosed please specify:

_____

Notice to Recipient of Patient Health information
Certain health information including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information are subject to confidentiality rules under State law and Federal confidentiality rules (42CFR Part 42). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Confidentiality of HIV-Related Information Act and State law. Federal rules prohibit the use of health information use/disclosed with this authorization to criminally investigate or prosecute any alcohol or drug abuse patient.

Please note all sections of this form must be completed for this authorization to be valid.

_____ ____/____/_____
Signature of Patient/Legal Guardian/Legal Representative Date

_____ _____
Name of Personal Representative Relationship to Patient

If the Patient and/or Personal Representative is unable to sign please state the reason below and have two witnesses who can attest to the to the fact that the Patient and/or Personal Representative understand the nature of this release and freely gave his or her consent.

_____ ____/____/_____
Reason Patient and/or Personal Representative is unable to sign Date

_____ _____
Witness Signature Witness Signature

_____ _____
Witness Name (Please Print) Witness Name (Please Print)

Rev: April 14, 2003 101192

Abington Memorial Hospital
Clinical Information Services
Release of Information Division
1200 Old York Road
Abington, PA 19001

RELEASE OF INFORMATION FACT SHEET

PATIENT RIGHTS

Patients have the right to copies of their medical records. In order to preserve patient privacy, an authorization must be completed and **signed by** the patient/guardian. In the case of the deceased patient, the Executor of the decedent's estate or in the absence of an executor, the next of kin along with a short certificate (From the County Register of Wills) or the person responsible for the disposition for the remains may consent.
Proper photo identification will be requested prior to release of records.

AUTHORIZATION

The form must be completed in it's entirety or write N/A. Please be specific regarding the information to be released such as an **abstract,** discharge summary or specific test results along with the dates of service.
An **Abstract** is a composite of the record that is most helpful to our patients and contains the information that is sent to physicians for continuity of care.
The abstract contains the discharge summary, history and physical, consultation reports, all operations, diagnostic and laboratory results.

COPY FEES

There are no charges for records to be sent to physicians or medical facilities for continuity of patient care.
To request records for personal use, there is a charge in accordance with HIPPA and Pennsylvania State law.
For copies of **paper** records which range from August 1994 to the present for inpatient and Same Day Procedure records and Emergency records from March 1997 to present the charges are as follows:

1-20 pages	$1.33 a page
21-60 pages	$0.99 a page
over 60 pages	$0.33 a page

Plus postage fees

RELEASE OF INFORMATION

Hours of operation: Monday – Friday – 8:30 am – 5:00 pm
Phone Number – 215-481-4435
Fax Number – 215-481-3139