Main Line Health
Jefferson Health System

☐ Bryn Mawr Hospital 130 South Bryn Mawr Avenue Bryn Mawr, PA 19010 Attn: Medical Records	☐ Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355 Attn: Medical Records	☐ Lankenau Hospital 100 Lancaster Avenue Wynnewood, PA 19096 Attn: Medical Records	☐ Paoli Memorial Hospital 255 West Lancaster Avenue Paoli, PA 19301 Attn: Medical Records

Authorization for Disclosure of Health Information

I hereby authorize _____ to release medical information from the
(Name of Institution)

records of:
Patient Name: _____ D.O.B.: _____ SS#: _____

Covering the period(s) of care (list applicable dates of treatment): _____

Information to be disclosed (check all applicable items to be released; for a complete chart copy, place a check in all boxes)

☐ Discharge Summary	☐ ER Record	☐ Progress Notes
☐ Discharge Instructions	☐ Xray Reports	☐ Medication Records
☐ History and Physical	☐ Lab Reports	☐ Doctor's Orders
☐ Consultations	☐ EKG/ECG Tests	☐ Nurse's Notes
☐ Operative Report	☐ Therapy Notes	
☐ Other (please specify): _____		

I understand that this will include information relating to (check if applicable to the patient's records):
☐ AIDS/HIV ☐ Psychiatric Care/Treatment ☐ Treatment for Drug or Alcohol use/abuse

This information is tho be disclosed to:
Name of Person or Institution: _____

Address: _____

City/State/Zip Code: _____ Phone # (for questions): _____

For the purpose of (required): _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician, and I agree to pay such charges.

X _____ _____ _____
(Signature of patient or Guardian) (Relationship to Patient) (date)

_____ _____
(Signature of Witness) (date)

Verbal Release of Mental Health Information:

Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____ was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

_____ _____ _____ _____
(Witness) (Date) (Witness) (Date)