AUTHORIZATION TO RELEASE MEDICAL INFORMATION

- PATIENT ACCESS FEE MAY APPLY -

Patient Name: _____
Address: _____
Address: _____
Birthdate: _____
Medical Record No.: _____
Invoice Number: _____

All provider entities of the Geisinger Health System Foundation (which is not a provider entity) including Geisinger Medical Center (all campuses), Geisinger Wyoming Valley Medical Center (all campuses), Geisinger Clinic (all sites), Geisinger-Community Medical Center (all campuses), Geisinger-Bloomsburg Hospital, Geisinger-Lewistown Hospital, Holy Spirit Hospital (all campuses), Holy Spirit Medical Group (all sites) **and all other provider entities** but **excluding** Marworth, Geisinger Medical Management Corporation and Geisinger Community Health Services.

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

_____ _____
(Name of hospital, company or person to whom the information will be released) (Telephone Number)

_____
(Address of receiving party)

for the purpose of: ☐ continuation of medical treatment ☐ payment of bill ☐ Worker's Compensation ☐ education ☐ legal purposes ☐ insurance purposes ☐ at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from _____ **to** _____
("present" equals date of signature)

SPECIFIC INFORMATION TO RELEASE:

☐ Clinic Notes	☐ Discharge Summary	☐ History & Physical	☐ Medications	☐ X-Ray Reports
☐ Colonoscopy	☐ EEG, EKG, Stress Test	☐ Immunizations	☐ Operation Report(s)	
☐ Consultation Report(s)	☐ Emergency Dept. Notes	☐ Itemized Bills	☐ Pathology Reports	
☐ Disability/FMLA Form	☐ Endoscopy	☐ Laboratory Reports	☐ X-Ray Films	

☐ Other (specify) _____
☐ Other (specify) _____

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I also understand that this consent will expire six months after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

Patient Initials	Parent/ Guardian Initials	**If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.**
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization.
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation information may be released to the recipient noted on the signed authorization.
_____ (initials)	_____ (initials)	My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time: _____ **Patient Signature:** _____
Date/Time: _____ Witness Signature: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign authorization because: _____

Date/Time: _____ **Signature:** _____ **Relationship:** _____
(Parent/legal or personal representative)

Date/Time: _____ Witness Signature: _____

**********COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT**********

White Copy: Medical Record *Yellow Copy: Patient*