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

____ Physical Therapy

____ Occupational Therapy

____ Speech Therapy

____ Therapy Initial Evaluation(s), Progress Note(s), Discharge Summary(s)

____ Other _____

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.

DO NOT USE UNAPPROVED ABBREVIATIONS

Date _____

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

____ Further Medical Care	____ Personal
____ Insurance Eligibility/Benefits	____ Changing Physicians
____ Legal Investigation or Action	____ 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:** _____

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