FRIENDS HOSPITAL

Authorization to Obtain or Release Protected Health Information

Attach patient label OR fill in information below.

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Admission Date: _____

I authorize friends hospital to obtain information from and/or release information to:

_____ _____ _____

Name of Person or Entity | Phone Number | Fax Number

_____ _____

Street Address | City, State, Zip

Additional Instructions: _____

Friends Hospital, 4641 Roosevelt Blvd, Philadelphia, PA 19124, Phone: 215-831-4600, Medical Record Fax: 215-831-4789

Please **INITIAL** below to signify that you consent to the additional specific information to be released to the above individual/entity:

_____ Drug/Alcohol Related Information

_____ HIV or AIDS Related Information

_____ Psychiatric/Behavioral Health Information _____ **Do Not** release the following:_____

Information to be released:	☐ Verbal Communication	☐ Clinical Referral Packet
☐ Discharge Summary	☐ Abstract of Record (key components)	☐ Entire Record
☐ Physician's Psychiatric Evaluation	☐ History and Physical Exam Report	☐ Discharge Information/Continuing Care
☐ Nursing Assessment	☐ Psychosocial Assessment	☐ Initial Intake Assessment
☐ Medication Summary	☐ Lab/Study Results	☐ Other (Specify):_____

Purpose for which this Information is to be used:	☐ Continuing Care	☐ Collateral Contact	☐ School
☐ Legal (must give specific reason): _____	☐ Employment	☐ Disability Benefits	☐ Personal

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This Release of Information demonstrates compliance with HIPAA Standards for privacy, and all Federal and State guidelines. I have been informed to refer to the Notice for Privacy Practices regarding authorized disclosures. I confirm a legible copy of this authorization or my signature thereon may be used with the same effectiveness as an original. "Federal regulation (**42 CFR, Part 2**) prohibits anyone from making any further disclosure of this information unless it is expressly permitted by my written consent, or as otherwise permitted within such regulations. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." **[RM 203, 7.2] Rev. 4-12-04**. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing.

Validation: This authorization is in effect beginning _____ and expires _____ (not to exceed 180 days).

_____ _____

Patient Signature ***(including minor patients age 14-17)*** | Date

_____ _____

Parent/Guardian/Authorized Representative Signature (if applicable) | Date

_____ _____

Witness Signature | Date

Revocation: *I hereby revoke the above authorization – Signature:* _____ *Effective Date:* _____