FRIENDS HOSPITAL

Authorization to Obtain or Release Protected Health Information

Fill in information below or attach patient label

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Admission or Discharge Date: _____

I authorize Friends Hospital to obtain information from and/or release information to: ☐ **SELF**

_____ _____ _____

Name of Person or Entity | Phone Number | Fax Number

_____ _____

Street Address | City, State, Zip

Additional Instructions: _____ ☐ **To be Mailed** ☐ **To Pick up**

Friends Hospital, 4641 Roosevelt Blvd, Philadelphia, PA 19124, Phone: 215-831-3917, Medical Record Fax: 215-831-4789

Place **YOUR INITIALS** below to signify that you consent to the additional specific information to be released:

x_____ Drug/Alcohol Related Information

x_____ HIV or AIDS Related Information

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

Information to be released:

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

Purpose: ☐ Personal ☐ Continuing Care ☐ Employment ☐ Disability Benefits ☐ School ☐ Collateral Contact

☐ Legal (must give specific reason): _____

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 to begin on (today's date): _____ and expires on (future date): _____ (not to exceed 6 mos.)

x_____ _____

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:* _____

FRIENDS HOSPITAL	**Authorization to Obtain or Release Protected Health Information**	**INSTRUCTIONS page 2.** **PLEASE COMPLETE ALL SECTIONS ON THE AUTHORIZATION FORM**

PATIENT INFORMATION

- *Fill in your name, date of birth, and a phone number where you can be reached.*
- *Fill in the admission or discharge date when you were at Friends.*

RELEASE TO:

- *Check for yourself or fill in where you want your information to go.*
- *Please fill in the entire address or fax number.*
- *Choose to be mailed or to pick up when ready.*

PLACE YOUR INITIALS FOR SPECIFIC INFORMATION

- *You must put your Initials on each line next to the x, for additional consent.*

SPECIFY DOCUMENTS

- *Choose the documents you want released.*

SPECIFY THE REASON FOR YOUR REQUEST

- *Check the purpose or need for your records.*

AUTHORIZATION / VALIDATION

- *Read the Statement.*
- *Fill in the Start and Expiration Date – up to 180 days or 6 months.*

SIGNATURE

- *Sign and Date the document.*

Please Note:

We have 30 days to comply with your request, but often complete it much sooner.
Charges for discharged record copies may apply, as allowable by the State of Pennsylvania.
A Release of Information representative will contact you with details of any fees.
You must bring an official ID if you are picking up your records.

Please call if you have any questions 215-831-3917.

Mail your request to:
Friends Hospital, Attn.: Medical Records, 4641 Roosevelt Blvd., Philadelphia, PA 19124