Jefferson Health®

* 9 2 0 4 3 4 *

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:

CSN:

DOB: (AGE) Gender:

MRN:

ADM Date:

Complete or AFFIX EPIC LABEL

IMPORTANT: DO NOT WRITE IN MARGINS

Section 1: Patient Information

PATIENT NAME		SOCIAL SECURITY NO. **LAST 4 DIGITS ONLY**		DATE OF BIRTH
PATIENT ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

Section 2: Location(s) of Care

☐ Jefferson Methodist Hospital ☐ Jefferson Hospital for Neuroscience ☐ Thomas Jefferson University Hospital

☐ Jefferson Medical Group/Outpatient Practice (Provide the physician or practice name where you received care and the address of the practice)

_____

☐ Other:

_____

Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self:

Address: Telephone No:

Fax No:

For the Purpose of:

☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance Purposes ☐ Legal Purposes

☐ Lay Caregiver ☐ Benefits Assignment ☐ School Registration ☐ Camp Registrations

☐ Personal Access ☐ Other: _____

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Specific Information to Be Released

The information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

☐ **Abstract*** ☐ Discharge Summary ☐ Orders

☐ Designated Record Set ☐ Discharge Instructions ☐ Implants

☐ Office Notes/Visit Notes ☐ Operations Report ☐ Imaging Films (X-rays, Scans, CD)

☐ After Visit Summary ☐ Pathology Reports ☐ Photographs

☐ Immunizations ☐ Consultation Reports ☐ Itemized Bills

☐ Disability/FMLA Form ☐ Laboratory Results ☐ Catheterization Lab

☐ Medication List ☐ Imaging Reports ☐ ECG, EEG, Stress Tests

☐ Problem List ☐ Emergency Room Record ☐ History & Physical Exams

☐ Other (specify) _____

☐ **Exception:** I do not give permission to release (specify): _____

***An **abstract** is a composite of the record that is most helpful to our patients and contains the information that is sent to physicians for continuity of care. The abstract contains the discharge summary, history and physical, consultation reports, all operations, diagnostic and laboratory results.

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Section 5: Special Authorizations For Mental Health, Drug and Alcohol and HIV Records

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical record may contain "protected information" related to the following categories. My signature next to these items acknowledges my awareness and my authorization to release "protected information" in the record.

_____
Signature

Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider. (Confidential Alcohol and Drug Abuse Patient Information 42 C.F.R. Part II)

_____
Signature

Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician/provider. (PA Mental Health Procedure Act).

_____
Signature

HIV related information, if HIV-related tests were ordered by my physician/provider. (Confidentiality of HIV-Related Information Act, PA Law Act 148).

Information is being disclosed from records whose confidentiality is protected by Federal Law [42 C.F.R. Part II] and PA State Statutes [Title 55 Pa. Code 5100.32 and 5100.34 (a) and (b) and DAACA, 71 P.S. 1690.108 (b) & (c)].

Section 6: Authorization Signatures

AUTHORIZATION SIGNATURES

I hereby authorize Thomas Jefferson University (TJU), including the clinical operations referred to as Jefferson Health, which includes Thomas Jefferson University Hospitals, Inc. (TJUH, Inc.), and Jefferson University Physicians (JUP), and the above mentioned locations to disclose the health information as described above.

I understand the nature of this authorization and understand that it is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, except: (a) when this authorization is for the use or disclosure of health information obtained in a research study, or (b) when I have requested a service by Jefferson (for example, a medical second opinion) and the sole purpose of the service is to provide health information to a third party at my request.

I understand that I may revoke this authorization at any time by sending a written request to the address indicated on the back of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Authorization Expires *(insert date or event)*

☐ 1 year from date of authorization ☐ Other Date or Event (please specify): _____

If no expiration date is designated this authorization will expire six (6) months from the signature date.

Patient Signature: _____ Date Signed: _____

Signature of Parent/Legal Guardian/Authorized Representative: _____

Printed Name of Parent/Legal Guardian/Authorized Representative: _____

Unable to sign because: _____

Verbal Consent *(If the patient is physically unable to provide a signature. A verbal consent may be revoked by a verbal statement verified in writing by two witnesses.)* I witness that the patient was physically unable to provide a signature, but that he/she understood the nature of this release and freely gave his/her oral authorization.

Witness Signature	Witness Printed Name	Date

Witness Signature	Witness Printed Name	Date

☐ Attached is a copy of the appropriate legal document, which proved authority to act on behalf of the patient.

Records of deceased patients: If the requester is not the executor of the decedent's estate or if there is no executor or administrator then the requester certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains and the attached legal documentation confirms the above statement.

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Instructions for Completing the Authorization for Release of Protected Health Information Form

1. **Please complete all sections of the Authorization for Release of Protected Health Information Form.**
2. **The patient or legally authorized representative must sign and date the form.**
   Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:
   - emancipated minors may sign this form (a patient age 16 or older who has left the parental household, supports him/herself financially, and lives independently);
   - minors who have married, been pregnant, or graduated from high school may also sign this form;
   - minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
   - minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.
3. **Please mail the completed form to:**

Thomas Jefferson University Hospitals, Inc.
Health Information Management Department, Room 1323
2301 South Broad Street
Philadelphia, PA 19148

Phone: 215.955.6627
Email: HIM@jefferson.edu

Hours of Operation:
Monday – Friday 8:30 a.m. – 5:00 p.m.

Please Note:

Jefferson will charge for copying records in accordance with State and Federal Laws.

https://www.health.pa.gov/topics/Administrative/Pages/Medical-Record-Fees.aspx

Jefferson will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

Jefferson may deny this request under limited circumstances as provided for under federal or state law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.

Patients requesting mental health treatment records have the right to inspect the records to be released, subject to the limitations of 55 Pa. Stat. 5100.33.

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