



# Consent for Release of Information

			MEDICAL RECORD NO.
PATIENT NAME	SOCIAL SECURITY NO.		DATE OF BIRTH
PATIENT ADDRESS	STATE	ZIP CODE	TELEPHONE NO.

I, \_\_\_\_\_ do hereby consent to and authorize \_\_\_\_\_ to disclose to:

NAME OF DOCTOR / HOSPITAL / INSURANCE COMPANY / OTHER AGENCY/SELF:
ATTENTION:
ADDRESS:
FOR THE PURPOSE OF: <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> SocialSecurity/Disability <input type="checkbox"/> Personal <input type="checkbox"/> Other _____

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

**ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION.**

**I understand that my medical record may contain "protected" information related to these categories. My signature next to these items acknowledges my awareness.**

_____ SIGNATURE	<b>Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician (Confidential Alcohol and Drug Abuse Patient Information, 42C.F.R. Part II)</b>
_____ SIGNATURE	<b>Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician (PA Mental Health Procedure Act).</b>
_____ SIGNATURE	<b>HIV related information, if HIV-related tests were ordered by my physician (Confidentiality of HIV-Related Information Act, PA Law Act 148).</b>

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

The information to be released is:

<input type="checkbox"/> Demographics	<input type="checkbox"/> X-Ray Report	<input type="checkbox"/> Entire Paper Record	Date(s) of Admission/Discharge _____
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Diagnostic Films (x-rays, scans, etc.)	_____
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG, EEG, Stress	<input type="checkbox"/> Physician Orders	Date(s) of Service _____
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Medication Sheets	_____
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Cath Lab	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Abstract (Includes all of the boxes previously listed)		_____

EXCEPTION: I do not give permission to release (please specify): \_\_\_\_\_

I understand that I do not have to sign this form in order to receive treatment at Lehigh Valley Hospital or Lehigh Valley Hospital - Muhlenberg. **Even though the consent for release of information is valid for 90 days**, I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Consent expires the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

SIGNATURE OF PARENT / LEGAL GUARDIAN /

AUTHORIZED REPRESENTATIVE: \_\_\_\_\_ WITNESS \_\_\_\_\_

Unable to sign because: \_\_\_\_\_ WITNESS \_\_\_\_\_

If you have any questions, please contact the Release of Information Specialist, at (610) 402-8240, 8:30 a.m.-4:00 p.m., Monday-Friday, or by mail at: Lehigh Valley Hospital, Attention - Release of Information, Cedar Crest & I-78, PO Box 689, Allentown, PA 18105-1556.

<b>FOR OFFICE USE ONLY:</b>					
Received:	Initial	Date	ID Confirmed:	Initial	Date
	_____	_____	Completed:	Initial	Date
	_____	_____		_____	_____