LEHIGH VALLEY H0SPITAL
ALLENTOWN, PA
LEHIGH VALLEY HOSPITAL - MUHLENBERG
BETHLEHEM, PA

2 5 9

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: ❒ Continuation of Care ❒ Insurance ❒ Legal ❒ SocialSecurity/Disability ❒ Personal ❒ 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
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)

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

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

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:

☐ Demographics	☐ X-Ray Report	☐ Entire Paper Record	Date(s) of Admission/Discharge
☐ History & Physical	☐ Laboratory Results	☐ Diagnostic Films (x-rays, scans, etc.)	_____
☐ Discharge Summary	☐ EKG, EEG, Stress	☐ Physician Orders	
☐ Operative Report	☐ Emergency Department	☐ Medication Sheets	Date(s) of Service
☐ Pathology Report	☐ Cath Lab	☐ Other _____	_____
☐ Consultation Report	☐ 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.

FOR OFFICE USE ONLY:

Received:		**ID Confirmed:**		**Completed:**	
Initial	Date	Initial	Date	Initial	Date

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