Lehigh Valley Health Network

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Consent for Release of Protected Health Information

Section 1: Patient Information

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

Section 2: Location(s) of Care

☐ Hospital * ☐ LVPG Physician Office ☐ Hospice ☐ Home Health
☐ Outpatient Clinic, Satellite location, or specified site ☐ Other Health Care Facility

Address Of LVPG Physician Office, Hospital Clinic, Satellite location(s), or Other Health Care Facility where you received care:

_____

_____

_____

*Includes Cedar Crest, Muhlenberg and 17th and Chew Hospital locations.

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: Fax#:

For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance Purposes

☐ Legal Purposes ☐ Personal Access ☐ 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 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:

☐ Record Summary*
☐ Office Notes/Visit Notes
☐ Immunizations
☐ Disability/FMLA Form
☐ Medication List
☐ Problem List
☐ Emergency Room Record
☐ History & Physical Exams
☐ Discharge Summary
☐ Operation Reports
☐ Pathology Reports
☐ Consultation Reports
☐ Laboratory Results
☐ X-Ray Reports
☐ EKG, EEG, Stress Tests
☐ Physician Orders
☐ Diagnostic Films (x-rays, scans)
☐ Photographs
☐ Itemized Bills
☐ Catheterization Lab
☐ Entire Record (includes records from other facilities)
☐ Other (specify)_____

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

* For explanation of Record Summary, see Instructions for Completion.

Consent for Release of Protected Health Information

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 understand that in order to process this request for the reproduction of medical record information on a timely basis, Lehigh Valley Health Network may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I do not have to sign this form in order to receive treatment at Lehigh Valley Health Network. **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 any action that has already been taken as authorized by this form will remain in force in order to achieve the purposes for which it is given. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Date Consent Expires: _____

Patient Signature: _____ Date Signed: _____

Signature of Parent/Legal Guardian/Authorized Representative: _____

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

Unable to sign because: _____

Witness signature: _____

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

CONTACT INFORMATION, MAILING/FAXING INSTRUCTIONS:

Mail/fax the completed form to the appropriate LVHN location or other facility where you received care as follows:

Hospital, (Inpatient and Outpatient Visits) Records:
Lehigh Valley Health Network - Attn. Release of Information
Cedar Crest and I-78 Box 689
Allentown, PA 18105-1556
Phone: 610-402-8240 Mon.-Fri. 8:30AM to 4:00 PM
Fax: 484-884-3824

Home Care and Hospice Records:
2166 12th Street, Allentown, PA 18103
Phone: 610-969-0300
Fax: 610-969-0454

LVPG Physician Office Records and Satellite Locations:
Mail or fax to the physician office or satellite location where you received care. Please see http://www.lvpg.org for a listing of LVPG physician practice locations. Please see http://lvhn.org for a listing of satellite locations.

Other Facility:
_____
_____
_____

For office use only:

MRN#: _____ Encounter#: _____

Received: _____ Initial and Date ID Confirmed: _____ Initial and Date Completed : _____ Initial and Date

Lehigh Valley Health Network

CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

INSTRUCTIONS FOR COMPLETION

Lehigh Valley Health Network (LVHN) maintains medical records for all services provided in our hospitals, physician office practices (Lehigh Valley Physician Group), home health and hospice services and other outpatient settings both on and off hospital campuses.

Please follow these instructions very carefully when completing each section of the "Consent for Release of Personal Health Information" form so that we may process your request without delay:

Section 1: Patient Information

Enter the patient's name (maiden or former name, if applicable), social security number, date of birth, address and telephone number.

Section 2 : Location(s) of Care

- Check the box for the location of the records you want released.
- If you are requesting records from an LVPG physician practice, LVHN Hospital Clinic, LVHN Satellite location, or Other Health Care Facility, write the name and address of the location(s) where you received your care.

Section 3: Release Records To:

- Enter the name, address and telephone number of the physician or medical practitioner, hospital, company or person to whom information will be released.
- Check the box that best describes the purpose of your request.

Section 4: Specific Information To Be Released:

- List the time period (dates you received care) for the records to be released. If you are unsure of dates of service, use an estimated date and place a question mark (?) next to the estimated date range.
- Check the types of information to be released. There may be a charge for copying and processing your records. You may reduce the copying costs by requesting a "record summary" rather than the entire medical record. The "record summary" is a set of key documents such as history and physical, recent test results, operative reports, discharge summaries, consultations, problem list, medication list, and recent office visits routinely provided to physicians for continuing care.

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

If you are requesting release of information in any of the three (3) protected information categories, i.e. drug and alcohol testing and treatment, mental health treatment or HIV information, you (either the patient or patient's legal representative) must sign the line in front of the protected information category that you are authorizing for release.

Section 6: Authorization Signatures

- You (either the patient or patient's legal representative) must sign and date the form.
- If you are a legal Guardian, Executor or Administrator of the Estate or Power of Attorney (Agent) for the patient, you must submit a copy of the appropriate legal document that proves you have authority to act on the patient's behalf. This document must accompany the consent form.

- If you are physically unable to sign this form or sign it with a mark ("X"), the signature of a witness must be obtained.
- This consent for release of information is valid for 90 days after you sign it. You may make this release of information valid for more or less than 90 days by placing a different date on the line "Date Consent Expires."

Fees Charged for Release of Information:
Under Pennsylvania Law, specific charges may apply for release of medical records including copying and shipping charges. After determining the cost for copying these records, you may receive an invoice from MRO. MRO is a release of information / document management company that processes medical records releases for LVHN. For more information, please see Contact Information below.

Contact Information, Mailing/Faxing Instructions:
Mail or submit the completed form to the appropriate LVHN location as follows:

Hospital, (Inpatient and Outpatient Visits):
Lehigh Valley Health Network – Attn. Release of Information
Cedar Crest and I-78 Box 689
Allentown, PA 18105-1556
Phone: 610-402-8240 Mon.-Fri. 8:30AM to 4:00 PM
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Mail or fax to the physician office or satellite location where you received care. Please see http://www.lvpg.org/ for a listing of LVPG physician practice locations. Please see http://lvhn.org for a listing of satellite locations.