Lehigh Valley Health Network

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1: Patient Information

****For timely processing, please PRINT clearly****

PATIENT NAME	SOCIAL SECURITY NO. (last 4 digits) XXX-XX-_____	DATE OF BIRTH
ADDRESS CITY STATE ZIP		TELEPHONE #

Section 2: Location(s) of Care

Hospital / ASC

☐ 17th & Chew ☐ Muhlenberg ☐ Cedar Crest ☐ Hecktown Oaks ☐ Hazleton ☐ Pocono ☐ Schuylkill ☐ Macungie
☐ Highland Ave (FKA Coordinated Bethlehem) ☐ 1503 N. Cedar Crest (FKA Coordinated Allentown) ☐ Dickson City ☐ Carbon
☐ Ambulatory Surgery Center (please specify):_____
Hospital Outpatient Department (please specify): _____

Practice / Provider

☐ Lehigh Valley Physician Group ☐ Valley Health Partners
Name of Practices or Providers
_____
Address
_____
City/State Phone
_____

Section 3: Release Records to *(Where do you want us to send your medical records?)*:

I consent to and authorize the release of information from my medical record from the above location(s) to:

Name of Doctor/Hospital/Person/Other/Self

Address: Fax#:

For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance ☐ Lay Caregiver ☐ Legal Purposes ☐ Personal Use
☐ Other: _____

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

Section 4: Method of Sending Records *(How do you want us to send your medical records?)*:

☐ Secure email: _____
☐ Fax: _____
☐ Mailing address: _____

Section 5: Specific Dates of Service/Information To Be Released:

The information to be released will cover the time frame from_____ to _____ (Cannot be a future date)

☐ Record Summary*
☐ Discharge Instructions (AVS)
☐ Emergency Room Record
☐ Office Notes / Visit Notes
☐ Immunizations
☐ History & Physical (H&P)
☐ Entire Record
☐ Operative Reports
☐ Discharge Summary
☐ Consultation Reports
☐ Lab Results
☐ X-Ray/Other Imaging Reports
☐ EKG, EEG, Stress Tests
☐ Photographs
☐ Physician Orders
☐ Therapy Notes (PT/OT)
☐ Radiology / Imaging Films on CD
(Note: Request may be fufilled by another dept.)

☐ Other:_____
☐ Exception: I do not give permission to release: _____

* Record Summary typically includes key documents, such as H&P, operative reports, discharge summaries, consultations, problem list, medication list, recent test results and recent office visits routinely provided to physicians for continuity of care. Typically includes most recent 2 years of records.

Section 6: Special Authorizations for HIV, Mental Health and Drug / Alcohol Records:

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, Psychiatric Care and Treatment, Treatment for Drug/Alcohol Abuse. Please initial to indicate your understanding and authorization for the release of these records.

AIDS/HIV diagnosis and/or treatment records (PA Law Act 148)	☐ No, do not release	☐ Yes, release - Initials _____
Psychiatric care and treatment records (PA Mental Health Procedure Act)	☐ No, do not release	☐ Yes, release - Initials _____
Drug/Alcohol Abuse treatment records (42 CFR Part II)	☐ No, do not release	☐ Yes, release - Initials _____

Section 7: Authorization Signatures

This authorization is valid for 6 months from the date of signature on this request. I understand that this authorization may be revoked by me at any time by written notification to this facility. I understand that genetic information may be released as part of my health information. If this request for medical records has already been completed, the authorization will remain on file. In addition, in order to process this request for 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 have the right to request a copy of this authorization. A copy of this authorization is as valid as the original. ***Electronic signatures will not be accepted***

Patient Signature_____ Date Signed_____

Printed Name_____

Signature of Authorized Representative:_____ Date Signed_____

Printed Name of Authorized Representative:_____

Relationship: ☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

Records of deceased patients: Must provide a copy of the Letter of Administration from the Court naming the personal representative. If not available, alternatively supply a copy of the death certificate which names the informant or next of kin. (PA Code 115.29)

For completion by STAFF at Behavioral Health only	**BEHAVORIAL HEALTH STAFF ONLY:**
	Name of staff obtaining consent: _____
	Staff signature: _____ Date: _____
	The patient has consented to the release of their protected health information, and they are physically unable to provide their signature:
	Staff (witness) signature #1 _____ Date _____
	Staff (witness) signature #2 _____ Date _____

Health care facilities are authorized in Pennsylvania State & Government Regulations to charge for this reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Section 8: Contact Information - Address/Fax/Email/Phone:

Send this completed authorization form with any appropriate legal documentation, if applicable to one or more of the following locations, based on where the patient received their care:

Facility Name:	Mail	Fax	E-mail	Phone:
Lehigh Valley Hospital (Cedar Crest, Muhlenberg, 17th & Chew, Hecktown Oaks, Carbon, Highland Ave, 1503 N. Cedar Crest, Macungie)	LVH–HIM Dept Cedar Crest Blvd. & I-78 PO Box 689 Allentown, PA 18105-1556	610-402-5823	ROIMack@lvhn.org	610-402-8240
Lehigh Valley Hospital–Hazleton	LVH–H HIM Dept 700 E. Broad St. Hazleton, PA 18201	570-501-4930	ROIHazleton@lvhn.org	570-501-4131
Lehigh Valley Hospital–Pocono	LVH–P HIM Dept 206 E. Brown St. East Stroudsburg, PA 18301-3006	570-476-3709	ROIPocono@lvhn.org	570-476-3388
Lehigh Valley Hospital – Schuylkill	LVH–S HIM Dept 700 E. Norwegian St. Pottsville, PA 17901-2710	570-621-4719	ROISchuylkill@lvhn.org	570-621-4562
Lehigh Valley Hospital – Dickson City	LVH–DC HIM Dept PO Box 4000 Allentown, PA 18103	610-841-5834	ROIDickson@lvhn.org	484-884-8557
LVPG and VHP Practices/Providers	Please send your completed authorization to your physician practice. For a listing of LVPG Providers and locations, go to www.lvhn.org and select Find a Doctor			