AUTHORIZATION TO RELEASE MEDICAL INFORMATION

FEE MAY APPLY

Patient name: _____
Address: _____
City, State, Zip: _____
Date of birth: _____
Medical record number: _____
Phone number: _____

This form is used by all provider entities of the Geisinger Health (which is not a provider entity) including Geisinger Medical Center (all campuses), Geisinger Wyoming Valley Medical Center (all campuses), Geisinger Clinic (all sites), Geisinger Community Medical Center (all campuses), Geisinger Bloomsburg Hospital, Geisinger Lewistown Hospital,Geisinger Jersey Shore Hospital, Geisinger Medical Center Muncy, and all other provider entities as outlined in the Geisinger Notice of Privacy Practices ***but excluding*** Marworth, and Geisinger Community Health Services.

I am requesting records from the following Geisinger entities:

☐ **All Sites** ☐ **Specific Clinic(s) or Hospital(s):** _____

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

Name of hospital, company, or person to whom the information will be released to: _____

Complete address: _____

Telephone number: _____ Fax number: _____ Email address: _____

***I am requesting that the information be produced (choose one):** ☐ Paper copies ☐ Fax ☐ Download to Email ☐ CD

***For the purpose of:** ☐ continuation of medical treatment ☐ payment of bill ☐ Worker's Compensation ☐ education

☐ legal purposes ☐ insurance purposes ☐ at the request of the patient or the patient's legal representative

☐ Other (specify): _____

*The information to be released will cover the **time period** from _____/_____/_____ to _____/_____/_____ . ("present" equals date of signature)

***SPECIFIC INFORMATION TO RELEASE:**

☐ Clinic Notes	☐ EEG, EKG, Stress Test	☐ Immunizations	☐ Pathology Reports
☐ Colonoscopy	☐ Emergency Dept. Notes	☐ Laboratory Reports	☐ X-Ray Reports
☐ Consultation Report(s)	☐ Endoscopy	☐ Medications	☐ X-Ray Films
☐ Discharge Summary	☐ History & Physical	☐ Operative Report(s)	☐ Itemized Bills

☐ Other (specify): _____

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the Geisinger Privacy Office immediately at systemprivacyoffice@geisinger.edu or 570-271-7360 if I wish to revoke this authorization. I also understand that this consent will expire six months after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party

SPECIAL AUTHORIZATION (IF APPLICABLE)

Patient initials	Parent/Guardian initials	If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released.
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment concerning my inpatient or outpatient mental health/rehabilitation treatment may be released.
_____ (initials)	_____ (initials)	My testing, diagnosis or treatment for HIV/AIDS may be released.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time: _____ **Patient Signature:** _____ **Staff Signature:** _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: _____

Date/Time: _____ **Signature:** _____ **Staff Signature:** _____
(Parent/legal or personal representative)

If Verbal consent: Witness #1 Date/Time _____ **Signature:** _____

If Verbal consent: Witness #2 Date/Time _____ **Signature:** _____
(Parent/legal or personal representative)

Description of personal representative's authority to act for the patient: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT******