

Consent for Release of Information

MEDICAL RECORD # _____

PATIENT NAME, SOCIAL SECURITY NO., DATE OF BIRTH, PATIENT ADDRESS, TELEPHONE NO.

I, _____ do hereby consent to and authorize _____ to disclose to:

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY:
ATTENTION
ADDRESSEE
FOR THE PURPOSE OF

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 and my authorization to release this "protected" information.

Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician (Confidential Alcohol and Drug Abuse Patient Information, 42 C.F.R. Part II)
Psychiatric or psychological information, if psychiatric or psychological treatment was given by physician (PA Mental Health Procedure Act).
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 [42 C.F.R. Part II] and PA State Statutes [Title 55 PA Code 5100.32 and 5100.34 (a) & (b) and DAACA, 71 P.S. 1690.108 (b) & (c)].

The information to be released is:

- Provider's Notes, Medical History and Examination, Diagnostic Tests, Immunization Record, Entire Record

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

I understand that I do not have to sign this specific form in order to receive treatment from Lehigh Valley Physician Group. 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.

Dated this _____ day of _____, 20_____

Consent expires the _____ day of _____, 20_____

PATIENT SIGNATURE _____ WITNESS TO SIGNATURE _____

SIGNATURE OF PARENT/LEGAL GUARDIAN/ AUTHORIZED REPRESENTATIVE: _____

Unable to sign because: _____

FOR OFFICE USE ONLY:

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