

Authorization for Disclosure of Health Information

Patient Name	Date of Birth	Medical Record #
Address	Telephone Number	Social Security #

Disclosed Information (check all items to be released)

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Record | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Doctor's Orders |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Tests | <input type="checkbox"/> Nurse's Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Billing Records |

 Other (please specify) _____

Covering the period(s) of care (list applicable dates of treatment) _____

Information Provided To

Name of Person or Institution	
Address	
City/State/Zip Code	Telephone Number

Purpose/Use Of The Requested Information

-
- Personal use by patient
-
-
- Sharing with other health care providers
-
-
- Other (please describe) _____

Authorization Expires (insert date or event)

-
- 1 year from date of authorization
-
-
- Other Date (please specify) _____
-
-
- Event (please specify) _____

Authorization

I hereby authorize Thomas Jefferson University Hospitals, Inc. ("TJUH") to disclose the health information described above.

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 and alcohol abuse. Please check appropriate box(es) below.

AIDS/HIV Information

-
- Yes, disclose
-
-
- No, do not disclose

Psychiatric Care/Treatment

-
- Yes, disclose
-
-
- No, do not disclose

Treatment for Drug or Alcohol use/abuse

-
- Yes, disclose
-
-
- No, do not disclose

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient or Personal Representative	Print Name	Date
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Relationship of Personal Representative to Patient	Date
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If Authorization is signed by someone other than the patient, please state reason.

Instructions For Completing The Authorization For Disclosure Of Health Information Form

1. Please complete all sections of the Authorization for Disclosure of Health Information Form.
2. The patient or legally authorized representative must sign and date the form.
Generally, only a patient may authorize release of his/her medical information.
Exceptions to the rule are as follows:
 - a. Authorization of minors – If the patient is a minor (under 18 years of age) the authorization must be signed by a parent or legal guardian. At the discretion of TJUH, two signatures may be required to release a minor's records.
 - b. Emancipated minors – An emancipated minor is a minor age 16 or older who has left the parental household and established himself as a separate entity. A minor who is married, is or has been pregnant or who is a high school graduate is also considered emancipated. Emancipated minors can consent to their own treatment and the authorization for release of medical information.
 - c. A minor who has been diagnosed with a venereal disease, a substance abuse problem or was treated to determine pregnancy may consent to treatment of that disease or condition and must authorize release of any medical information related to that disease or condition.
 - d. Minors 14 years of age and older must authorize release of their psychiatric treatment records.
 - e. Authorization after death – An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
 - f. Authorization of the Legally Incompetent Patient – If the patient is deemed legally incompetent, then the patient's legally authorized representative must sign the authorization for release of information.

The hospital reserves the right to request proof of representation.

Please Note

TJUH will charge for copying records in accordance with Pennsylvania law.

TJUH will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by relevant Federal law.

TJUH will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information is not maintained on site. If TJUH is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.

TJUH may deny this request under limited circumstances as provided for under federal law. TJUH will notify you if it denies your request to access or obtain a copy of the requested information. If TJUH denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the TJUH Privacy Officer at the following address:

Thomas Jefferson University Hospitals, Inc.
Privacy Officer
111 South 11th St.
Philadelphia, PA 19107