

**Albert Einstein Healthcare Network  
AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION**

AEMC     MossRehab     Willowcrest     Germantown     Other \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Work Phone Number

**RELEASE OF INFORMATION TO:**

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone#: \_\_\_\_\_

**INFORMATION TO BE RELEASED: (Must be Specific)**

Copies of medical and/or psychiatric information from the health care record(s) pertaining to the hospitalization(s)/treatment(s) of:

Specify Dates of Treatment: \_\_\_\_\_

**PURPOSE OR NEED FOR THE DISCLOSURE IS:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Continued Care     | <input type="checkbox"/> Third Party/Insurance Review | <input type="checkbox"/> School Registration |
| <input type="checkbox"/> Legal Consultation | <input type="checkbox"/> Benefits Assignment          | <input type="checkbox"/> Camp Registration   |
| <input type="checkbox"/> Other _____        |   |  |

**INFORMATION TO BE RELEASED:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Designated Record Set/Abstract                     | <input type="checkbox"/> Discharge/Clinical Summary | <input type="checkbox"/> Immunization Record       |
| <input type="checkbox"/> Operative Procedure Report                         | <input type="checkbox"/> Consultation Report(s)     | <input type="checkbox"/> History & Physical Report |
| <input type="checkbox"/> Laboratory Report                                  | <input type="checkbox"/> Pathology Report           | <input type="checkbox"/> Radiology Report          |
| <input type="checkbox"/> Emergency Record                                   | <input type="checkbox"/> Other _____                |  |
| <input type="checkbox"/> Entire Medical Record for Visit(s) specified above |   |  |

**EXPIRATION DATE:**

Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication to the Albert Einstein Healthcare Network and/or that my consent expires under the circumstances above.

*All Record Pickups will be held for 8 weeks only.*

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Legal Representative

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Witnessed By

\_\_\_\_\_  
Date

- Pick-up     Mail     Fax     Prepaid     Messenger

\_\_\_\_\_  
HIM Staff Completing Request: