Main Line Health
Jefferson Health System

☐ Bryn Mawr Hospital
130 South Bryn Mawr Avenue
Bryn Mawr, PA 19010

☐ Bryn Mawr Rehab
414 Paoli Pike
Malvern, PA 19355

☐ Lankenau Hospital
100 Lancaster Avenue
Wynnewood, PA 19096

☐ Paoli Memorial Hospital
255 West Lancaster Avenue
Paoli, PA 19301

Authorization for Disclosure of Health Information

I hereby authorize _____ _____ to release medical information from the
(Name of Institution)
records of:
Patient Name:_____ D.O.B.:_____ SS#:_____

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

Information to be disclosed (check all applicable items to be released; for a complete chart copy, place a check in all boxes)

☐	Discharge Summary	☐	ER Record	☐	Progress Notes
☐	Discharge Instructions	☐	Xray Reports	☐	Medication Records
☐	History and Physical	☐	Lab Reports	☐	Doctor's Orders
☐	Consultations	☐	EKG/ECG Tests	☐	Nurse's Notes
☐	Operative Report	☐	Therapy Notes		

☐ Other (please specify):_____

I understand that this will include information relating to (check if applicable to the patient's records):
☐ AIDS/HIV ☐ Psychiatric Care/Treatment ☐ Treatment for Drug or Alcohol use/abuse

This information is to be disclosed to:
Name of Person or Institution:_____

Address:_____

City/State/Zip Code:_____ Phone # (for questions):_____

For the purpose of (required): _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician, and I agree to pay such charges.

_____ (Signature of patient or legal representative) _____ (Relationship to Patient) _____ (date)

_____ (Signature of Witness) _____ (date)

Verbal Release of Mental Health Information:
Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____ was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

_____ (Witness) _____ (Date) _____ (Witness) _____ (Date)