



Episcopal Campus

Temple University Hospital

AUTHORIZATION TO RELEASE SPECIAL INFORMATION

PATIENT IDENTIFICATION DATA

Full Name: _____ Date of Birth: _____ M/F: _____
Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____

Date of Hospitalization/Visit: _____

I hereby authorize TEMPLE UNIVERSITY HOSPITAL to furnish information from my medical records

TO:

Name of person or Organization

Address: _____ City: _____ State: _____ Zip Code: _____

Type of Access:

This information I am authorizing to be disclosed will be used for the following purpose:

- Sharing with other health care providers as needed for treatment purposes
My personal record
Review of record in department
Copies of my record
I understand if needed for my personal use there will be a fee that must be paid prior to my receiving the photocopied records.
Other (please describe):

Scope:

Specify nature and extent of information to be disclosed (check appropriate boxes):

- Most recent Discharge Summary
Most recent history and physical
Lab results, please specify dates and types if known
X-ray and imaging reports; please specify dates and types if known
Consultation reports; please specify doctors' names if known
Other, please describe:
Medication list
Entire record

Disclosure may include information relating to psychiatric, drug/alcohol and/or HIV or AIDS related information

This authorization is effective for the period from _____ to _____. If no expiration date is specified, it will expire 6 months from the date on which it was signed.

As required by the Health Information Portability and Accountability Act (HIPAA) you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request cannot be granted.

The authorization is subject to my revocation at any time by writing to the Custodian of Records, Temple University Hospital, Medical Records Department.
I understand that the revocation will not apply to information already released in response to this authorization.
I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that once the information is disclosed, it may be redisclosed by the recipient and federal privacy laws or regulations may not protect the information.
I understand authorizing the use or disclosure of the information identified above is voluntary and that I do not need to sign this form to ensure healthcare treatment.
This authorization form has been fully explained to me and I certify that I understand its contents.

Patient's Signature _____ Date _____

Witness _____ Signature of Witness _____

NOTE: Authorization must be signed by the patient or the next of kin in case of a minor or by legal guardian when the