HAHNEMANN UNIVERSITY HOSPITAL

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ **DOB:**_____

If the Authorization is for disclosures of psychotherapy notes, is about mental illness, mental health and developmental disabilities, then the following additional signatures and/or statements are required to be completed:

I, the undersigned, understand the nature of this release and I give this authorization freely.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed name of Personal Representative Date

_____
Description of Authority (Relationship to Patient)

_____ _____
Print name of Hospital Employee Accepting Signature Date

_____ _____
Signature of Hospital Employee Date

☐ [Employee check here if verbal authorization was obtained in the event that the patient is physically unable to provide a signature.]

_____ _____
Witness 1 Witness 2

"This information has been disclosed to you from records whose confidentiality is protected by State Statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."

MUST SEND A COPY OR SHOW A PICTURE IDENTIFICATION (I.E. DRIVER'S LICENSE ID) WITH THIS REQUEST

Send back to the Medical Records Department; Hahnemann University Hospital, Broad and Vine Streets, Mail Stop 511, Philadelphia, Pennsylvania, 19102 (Facsimile: (215) 762-7127).

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____
Print name of employee validating identity

_____
Signature of employee validating identity