



**Jeanes Hospital**  
 Temple University  
 Health System

**Health Information Management Department**  
 Phone: (215) 728-2076 Fax: (215) 728-3363

**Authorization to Use or Disclose Health Information**

- HIM     RAD     LAB     CARD/RESP  
 BH     SHA     REHAB     OTHER

I hereby authorize Jeanes Hospital to use or disclosure medical records or other information regarding my treatment, hospitalization and/or outpatient care for my impairment(s). I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Pt Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MR#: \_\_\_\_\_

Covering the period(s) of hospitalization from:

Adm Date: \_\_\_\_\_ D/C Date: \_\_\_\_\_ Outpt Date: \_\_\_\_\_ ED Date: \_\_\_\_\_

Information to be released or disclosed: (check all that apply)

- |                                              |                                            |                                           |
|----------------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Face Sheet          | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> History & Physical  | <input type="checkbox"/> Pathology Report  | <input type="checkbox"/> Radiology Film   |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Pathology Slides  | <input type="checkbox"/> Emergency Record |
| <input type="checkbox"/> Operative Report    | <input type="checkbox"/> Cardiology Report | <input type="checkbox"/> SDS Record       |
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Vascular Report   | <input type="checkbox"/> Record Abstract  |

Other (Specify): \_\_\_\_\_

Please print below the name and address of the person or entity receiving this information:

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

City/State/Zip: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Purpose of the Disclosure: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

This authorization will expire (insert date or event): \_\_\_\_\_  
 If not specified this authorization shall remain in effect for a period of ninety (90) days from the date of my signature.

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.