Thomas Jefferson University Hospital
Jefferson Health System

Thomas Jefferson University
Medical Record Department
Suite 2130 Gibbon Bldg.
111 S. 11th Street
Philadelphia, PA 19107

Authorization for Disclosure of Health Information

Patient Name

Medical Record #

Date of Birth

Social Security #

Disclosed Information (check all items to be released)

☐ Discharge Summary
☐ Discharge Instructions
☐ History and Physical
☐ Consultations
☐ Operative Report
☐ ER Record
☐ X-Ray Reports
☐ Lab Reports
☐ EKG/ECG Tests
☐ Therapy Notes
☐ Progress Notes
☐ Medication Records
☐ Doctor's Orders
☐ Nurse's Notes
☐ Billing Records
☐ Other (please specify)

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

Information Provided To

Name of Person or Institution

Address

City/State/Zip Code

Purpose/Use Of The Requested Information

☐ Personal use by patient
☐ Sharing with other health care providers
☐ Other (please describe)

Authorization Expires (insert date or event)

☐ 1 year from date of authorization
☐ Other Date (please specify) ____________________
☐ Event (please specify) ____________________

Authorization

I hereby authorize Thomas Jefferson University Hospitals, Inc. ("TJUH") to disclose the health information described above.

I understand that any information disclosed in response to this request will not include any information related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse unless specifically checked below.

☐ AIDS/HIV Information
☐ Psychiatric Care/Treatment
☐ Treatment for Drug or Alcohol use/abuse

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient or Personal Representative — Date

Relationship of Personal Representative to Patient — Date