

ACCESS/RELEASE OF INFORMATION

MEDICAL COLLEGE OF PENNSYLVANIA HOSPITAL

If I fail to specify an expiration date, event or condition, this authorization will expire on: _____
No more than 6 months

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy (with appropriate fees) the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director.

RELEASE OF ORIGINAL FILMS, PATHOLOGY SPECIMENS (indicate # and date of specimen released):

Film/Specimen	Date	Film/Specimen	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Film/Specimen to taken by/sent to:
Name: _____ Telephone: _____
Address: _____

These Films/Specimens are legally the property of Medical College of Pennsylvania Hospital and must be returned promptly after review.

Signature of Patient or Patient Representative _____ Date _____

If Signed by Patient Representative, Relationship to Patient _____ Signature of Witness _____

MUST SEND A COPY OR SHOW A PICTURE IDENTIFICATION (I.E. DRIVER'S LICENSE ID) WITH THIS REQUEST
Send back to the Department of Health Information Management; Medical College of Pennsylvania Hospital, 3300 Henry Avenue, Philadelphia, Pennsylvania, 19129 (Facsimile: (215) 843-5889).

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*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 \_\_\_\_\_ Telephone Extension \_\_\_\_\_  
Signature of employee validating identity \_\_\_\_\_