



Medical Record Department
Phone: (215) 291-3516 Fax: (215) 291-3497

Authorization to Use or Disclose Health Information

- Medical Records, Radiology, Laboratory, Cardiology, Respiratory, IHC, OTHER

I hereby authorize Northeastern Hospital to use or disclosure medical records or other information regarding my treatment, hospitalization and/or outpatient care. 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)

- Face Sheet, History & Physical, Consultation Report, Operative Report, Discharge Summary, Laboratory Report, Pathology Report, Pathology Slides, Cardiology Report, Vascular Report, Radiology Report, Radiology Film, Emergency Record, SCU Record, 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 Medical Record 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.

###-### (04/03)