

PARKVIEW HOSPITAL, 1331 E. WYOMING AVE., PHILA., PA 19124

**SPECIAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

This form authorizes Parkview Hospital to release to:

\_\_\_\_\_ the following information: {Exact information required, MUST be specific}. \_\_\_\_\_

This information is required for the purpose of: X \_\_\_\_\_

PRINT NAME OF CLIENT/PATIENT: \_\_\_\_\_

The undersigned has been informed that he/she has the right to revoke consent at any time by oral or written request.

This authorization is therefore subject to revocation at any time except to the extent that action has been taken in reliance of the authorization.

This authorization is valid beginning on: X \_\_\_\_\_ and for 30 days, ending on: X \_\_\_\_\_

The undersigned has been informed of his/her right, subject to Section 7100.113 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material released.

This form has been fully explained and I certify that I understand its contents.

Signature of Client / Patient: X \_\_\_\_\_ Date: X \_\_\_\_\_

Signature of Person Authorized in Lieu of Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Verbal consent is acceptable if the client/patient is unable to provide a signature. Two witnesses attesting that the client/patient understood the nature of the release and freely gave his/her verbal consent MUST sign below.

Verbal consent was freely given by: \_\_\_\_\_

on: \_\_\_\_\_ as witnessed by: \_\_\_\_\_ / \_\_\_\_\_

Signature of Witness / Signature of Witness

\_\_\_\_\_ / \_\_\_\_\_

Title or Relationship Date

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