

ROXBOROUGH MEMORIAL 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 Roxborough Memorial Hospital and must be returned promptly after review.

 Signature of Patient or Legal Representative

 Date

 If Signed by Legal 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 Health Information Management Department (Medical Records); Roxborough Memorial Hospital, 5800 Ridge Avenue, 2nd Floor, Philadelphia, Pennsylvania, 19128

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as 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