RECORD RELEASE or REQUEST / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:____

Last First Middle

Home Address:____

____

Home Telephone:______________________ **Date of Birth**: ____________

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report

☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report

☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record

☐ Other____

Records for the period (dates) from _______________ to _______________

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

☐ **RELEASE Information To:** ☐ **REQUEST Information From:**

Name: ____

Address:______________________________________

City: ________________________ State: _________ Zip Code: _____________

Telephone: (_____)_______________ Fax: (____)____________________

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the __________ day of _______, 20____.

☐ Until St. Christopher's Pediatric Associates, LLC (SCPA) fulfills this request.

☐ Until the following event occurs: ____

☐ Other: ____

FORMAT:

☐ Electronic Copy ☐ Paper / Hardcopy

PURPOSE: I authorize St. Christopher's Pediatric Associates, LLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] ___________

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RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once St. Christopher's Pediatric Associates, LLC discloses my health information to the recipient, St. Christopher's Pediatric Associates, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that St. Christopher's Pediatric Associates, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at St. Christopher's Pediatric Associates, LLC; except, however, if my treatment at St. Christopher's Pediatric Associates, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case St. Christopher's Pediatric Associates, LLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to St. Christopher's Pediatric Associates, LLC's Privacy Office at the address listed below. The revocation will be effective immediately upon St. Christopher's Pediatric Associates, LLC receipt of my written notice, except that the revocation will not have any effect on any action taken by St. Christopher's Pediatric Associates, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact St. Christopher's Pediatric Associates, LLC Privacy Office by mail at by mail at 160 East Erie Avenue, Philadelphia, PA 19134, or by telephone at (215) 427-5340, or by e-mail at

SCHC-PrivacyOffice@tenethealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize St. Christopher's Pediatric Associates, LLC to use or disclose my health information in the manner described above.

____ _____________________

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

___________________________	____________________	____________________
Signature of Authorized Personal Representative	Relationship to Patient	Date