

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____
 Address: _____
 Address: _____
 Birthdate: _____
 Medical Record No.: _____
 Invoice Number: _____

• GEISINGER EMPLOYEE USE ONLY •

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822

<input checked="" type="checkbox"/> Geisinger South Wilkes-Barre
25 Church Street
Wilkes-Barre, PA 18765

<input checked="" type="checkbox"/> Geisinger Endoscopy Centre at
Geisinger - Scenery Park
State College, PA 16801 | <input checked="" type="checkbox"/> Geisinger Wyoming Valley Medical Center
1000 E. Mountain Boulevard
Wilkes-Barre, PA 18711

<input checked="" type="checkbox"/> GMC Outpatient Surgery - Woodbine
Danville, PA 17822

<input checked="" type="checkbox"/> Geisinger Wyoming Valley Medical Center -
Outpatient Surgery
Route 315
Wilkes-Barre, PA 18711 | <input checked="" type="checkbox"/> Geisinger Clinic

(Specify site and address)

<p style="text-align: right;">(AS APPLICABLE)</p> |
|---|--|---|

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

 (Name of hospital, company or person to whom the information will be released)

 (Telephone Number)

 (Address of receiving party)

for the purpose of: continuation of medical treatment payment of bill Worker's Compensation
 education legal purposes insurance purposes at the request of the patient or the patient's legal representative
 for personal access or other (specify): _____

The information to be released will cover the time period from _____ to _____
 ("present" equals date of signature)

SPECIFIC INFORMATION TO RELEASE:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Entire Record* | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Operation Report(s) |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> EEG, EKG, Stress Test | *All GHS Electronic | <input type="checkbox"/> Itemized Bills | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Emergency Room Notes | Health Information | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> Disability/FMLA Form | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Medications | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Other (specify) _____ | | | | |
| <input type="checkbox"/> Other (specify) _____ | | | | |

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I also understand that this consent will expire six months after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

Patient Parent/ Guardian Initials **If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.**

- | | | |
|---------------------|---------------------|---|
| _____
(initials) | _____
(initials) | My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization. |
| _____
(initials) | _____
(initials) | My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation information may be released to the recipient noted on the signed authorization. |
| _____
(initials) | _____
(initials) | My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization. |

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date: _____ Patient Signature: _____
 Date: _____ Witness Signature: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: _____

Date: _____ Signature: _____ Relationship: _____
 (Parent/legal or personal representative)

Date: _____ Witness Signature: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT*****

White Copy: Medical Record

Yellow Copy: Patient