UNIVERSAL AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Geisinger Health System[1]
Medical Reports MC 13-11
100 North Academy Avenue
Danville, PA 17822

Patient Name:

MRN:

Date of Birth:

Geisinger understands your medical care may be managed by both Geisinger and non-Geisinger healthcare teams. Your doctors believe that having a complete picture of your health status is important to providing quality medical care. This can be especially important in the case of an emergency room visit.

Your Geisinger healthcare team uses 'Computer Systems'[2] and paper documents to record care provided at a Geisinger office or hospital. We need your approval to share your Geisinger medical information with non-Geisinger healthcare teams involved in your medical care. We ask that you review and sign this authorization.

Here are the key points we want you to understand:

- By initialing and signing this authorization, you are giving us permission to release your medical information to non-Geisinger licensed healthcare teams who are involved in your care.
- This authorization covers the complete release of your medical information, current and future, and includes information on alcoholism, drug abuse, mental health, and HIV/AIDS if any apply to you.
- Protecting your medical information is very important to us. Security measures are in place to protect the privacy and confidentiality of your medical information.
- Non-Geisinger healthcare teams, who have access to the Computer Systems, will be able to view, print and retain your medical information. Therefore medical information may be further released by your non-Geisinger healthcare team and may no longer be protected by federal privacy regulations (HIPAA).
- This authorization will be in effect until you revoke or cancel it as described in our Notice of Privacy Practices. To revoke an authorization, please submit a written request at your next doctor's visit or send it to the address at the top of this page. We are not able to take back any uses or disclosures already made with your authorization.
- If you choose to not sign this authorization, treatment or payment services provided to you by Geisinger will not be affected. Concerns or questions about this authorization? You can call 1-800-275-6401 and ask for 'CareLink'.

I hereby authorize Geisinger to release my medical information to non-Geisinger licensed medical providers and their approved staff who are involved in my care for the purpose of my medical evaluation or treatment. This includes my medical information stored in Computer Systems and paper documents.

Patient Initials	Parent/ Guardian Initials	By initialing these 3 items, I acknowledge that information regarding these topics may be released as part of my medical information.
_____	_____	Alcoholism or drug abuse or drug dependency - evaluation, diagnosis and/or treatment
_____	_____	Mental health/rehabilitation or neuro-psychological issues - evaluation, diagnosis and/or treatment
_____	_____	HIV/AIDS - evaluation, diagnosis and/or treatment

Patient, age 14 and older, please date and sign here and initial all 3 items in the box above.

Date/Time: _____ **Patient Signature:** _____

If patient is a minor under age 18 (unemancipated) or if patient is unable to give consent, parent or legal guardian must also complete the following and initial all 3 items in the box above.

Date/Time:_____ **Parent/Legal Guardian Signature:** _____

Relationship to Patient: _____

1 'Geisinger Health System' is comprised of Geisinger Health System Foundation as parent and all subsidiary corporate entities of the health system.
2 'Computer Systems' include applications used to electronically store clinical patient data, but excludes Marworth clinical patient data.

******A copy of completed authorization form must be given to patient.******

White Copy - Geisinger *Yellow Copy - Patient*

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