AUTHORIZATION TO REQUEST MEDICAL INFORMATION FROM ANOTHER FACILITY

Patient Name: _____
Address: _____
Address: _____
Birthdate: _____
Medical Record Number: _____

I authorize the appropriate workforce member of Geisinger Health System
(name of requesting facility)
to request protected health information from another facility **for the purpose of**: ☒ continuation of medical treatment
☐ payment of bill ☐ data collection ☐ other (specify): _____

Name of Requestor: Heidi Foresman
Requesting Facility: Geisinger Health System Department: Destination Medicine
Street Address: 100 North Academy Avenue Mail code 01-35 Fax: 570-214-2990
City: Danville State: PA Zip Code: 17822

I authorize the following facility to release my medical information as described below:

Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

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

SPECIFIC INFORMATION TO RELEASE:

☒ Clinic Notes	☐ Discharge Summary	☒ History & Physical	☐ Immunizations	☐ Operation Report(s)
☐ Colonoscopy	☐ EEG, EKG, Stress Test		☐ Itemized Bills	☐ Pathology Report(s)
☐ Consultation Report(s)	☐ Emergency Dept. Notes		☒ Laboratory Reports	☐ X-ray Films
	☐ Endoscopy		☒ Medications	☐ X-ray Reports

☐ Other (specify) _____
☐ Other (specify) _____

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 facility immediately if I wish to **revoke** this authorization. I also understand that this consent will **expire six months after the date of signature or automatically when the records requested 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 Initials	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

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 because: _____

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

Date: _____ Witness Signature: _____

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

WHITE COPY: SEND TO RELEASING FACILITY YELLOW COPY: PATIENT