The Reading Hospital And Medical Center

6th Avenue and Spruce Street, West Reading, Pa 19612 p610 988 8252 f610 988 9777

Authorization for Release, Use and Disclosure of Protected Health Information

Last Name | First Name | Date of Birth | MRN

Address

Phone | Fax | Email

I authorize _____ to release my Medical Records to: ☐ Myself

Name of authorized Person, Doctor, Hospital, Agency or Other (include address) | Phone

For the reason of: | Fax

ATTENTION PATIENT:

I understand and authorize the release of this information with the exceptions of: _____

If included in the medical record, this authorization includes the release of information protected by: Confidentiality of HIV-Related Information Act (AIDS , HIV-related information or testing), Mental Health Procedures Act (Psychiatric disorders), Drug and Alcohol Abuse Control Act (Drug and/or Alcohol treatment).

The Information to be released is:

☐ Radiology Images	☐ Discharge Summary	☐ Labs	☐ Outpatient Clinic
☐ Radiology/ Imaging Reports	☐ Operative Report	☐ Pathology Reports	☐ Emergency/ Trauma Records
☐ Review Records	☐ Complete Medical Records	☐ Speech and Hearing	☐ PT/OT

☐ Abstract of Medical Records = H&P, Discharge Summary, Diagnostic Test Results, Consultations Reports, Operative and Procedure Reports, Pathology Reports, EKG's and Labs

☐ Electronic Abstract = Discharge Summary, Diagnostic Test Results, Problem List, Medication, Allergies and Procedure reports

☐ Other = _____

With the Date(s) of Service of:_____ and

I would like to receive this information VIA: ☐ **Paper** ☐ **CD** ☐ **Secure Email** **(from copy service, completion of additional form required)**

CD #_____

I understand the following:

- I may revoke authorization in writing at anytime , this revocation will not apply to information that has already been released in response to this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization.
- I have the right to inspect or copy the health information to be used or disclosed as permitted by law.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility, for benefits (if applicable)
- The Reading Hospital and Medical Center may receive compensation for medical record copying in accordance with PA law, 42Pa.C.S. §6152
- I understand this this consent will expire 90 days from the date below or upon my death, whichever occurs earlier

Signature of Patient or Authorized Representative | Date

Signature of Witness | Date

Printed Name of Patient

Printed Name of Witness

Relationship to Patient

Title/Department