Jefferson University Hospitals

*4956NS*

# Authorization for Disclosure of Health Information

| Patient Name | Date of Birth |
|---|---|
| | |

Full Address: Street/City/State/Zip

| Telephone Number | Medical Record # | Social Security Number **(last 4 digits only)**: |
|---|---|---|
| | | |

## Disclosed Information *(check all items to be released)* - COPYING FEE INFORMATION ON REVERSE

☐ Abstract (Pertinent Information)
An abstract may include a discharge summary, discharge instructions, the history and physical, operative report, laboratory reports, radiology reports, consultations, EKG and other cardiology reports, neurological testing, and other pertinent testing or reports.

☐ Discharge Summary
☐ Discharge Instructions
☐ Operative Report
☐ ER Record
☐ X-Ray Reports
☐ Lab Reports
☐ EKG/ECG Tests
☐ Entire Record

☐ Other (please specify): _____

Covering the period(s) of care (list applicable dates of treatment): _____

## Information Provided To

| Name of Person or Institution | Telephone Number |
|---|---|
| | |

Full Address: Street/City/State/Zip

## Purpose/Use Of The Requested Information

☐ Personal use by patient ☐ Sharing with other health care providers

☐ Other (please describe): _____

## Authorization Expires *(insert date or event)*

☐ 1 year from date of authorization ☐ Other Date (please specify): _____

☐ Event (please specify): _____

**If no expiration date is designated this authorization will expire six (6) months from the signature date.**

## Authorization

I hereby authorize Thomas Jefferson University Hospitals, Inc. ("TJUH") to disclose the health information described above.

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse. Please check appropriate box(es) below.

| **AIDS/HIV Information** | **Psychiatric Care/Treatment** | **Treatment for Drug or Alcohol use/abuse** |
|---|---|---|
| ☐ Yes, disclose | ☐ Yes, disclose | ☐ Yes, disclose |
| ☐ No, do not disclose | ☐ No, do not disclose | ☐ No, do not disclose |

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

**X** _____ _____
**Signature of Patient or Personal Representative** **Date**

_____ _____
**Print Name** **Relationship of Personal Representative to Patient**

**If Authorization is signed by someone other than the patient, please state reason.**

_____

_____



***Please read instructions on reverse.***

# Instructions for Completing the Authorization for Disclosure of Health Information Form

1. Please complete all sections of the Authorization for Disclosure of Health Information Form.

2. The patient or legally authorized representative must sign and date the form. Generally, only a patient may authorize release of his/her medical information. Exceptions to the rule are as follows:
   a. **Authorization of Minors:** If the patient is a minor (under 18 years of age) the authorization must be signed by a parent or legal guardian. At the discretion of the department releasing the PHI, two signatures may be required to release a minor's records.
   b. **Mental Health Records:** Minors 14 years of age and older may consent to mental health treatment and, therefore, may also authorize release of their mental health treatment records. If the parent or legal guardian provides consent to mental health treatment of a minor 14 years of age or older, the parent/guardian shall have the right to information necessary for providing that consent, including symptoms and conditions to be treated, medications and other treatments to be provided, risks and benefits, and expected results.
   c. **Regulatory Authority:** Minors who are married, have been pregnant, or are high school graduates may consent to their own treatment and, therefore, may also authorize release of the medical records for that treatment. Minors may also consent to treatment and authorize record release for their own minor children.
   d. **Emancipated Minors:** An emancipated minor is a minor who has left the parental household, supports him/herself financially, and lives independently. Emancipated minors can consent to their own treatment and, therefore, may also authorize release of their medical information.
   e. **Minors and Highly Confidential Information:** Minors who have been diagnosed with a venereal disease, a substance abuse problem or were treated to determine pregnancy may consent to treatment for that disease or condition and, therefore, may authorize release of any medical information related to that treatment.
   f. **Authorization after Death:** An authorization must be signed by the executor of the decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
   g. **Authorization of the Legally Incompetent Patient:** If the patient is deemed legally incompetent, then the patient's legally authorized representative (e.g., guardian or agent under a durable power of attorney) may sign the authorization for release of information.

   **TJUH reserves the right to request proof of representation.**

3. Please mail the completed form to:

**Thomas Jefferson University Hospitals, Inc.**
**Health Information Management Department**
**111 South 11th Street, Gibbon Building, Suite 1950**
**Philadelphia, PA 19107**

## Please Note

TJUH will charge for copying records in accordance with Pennsylvania Department of Health Notice regulated by Act 26 (41Pa.B.6453) and the Health Insurance Portability and Accountability Act (45CFR Parts 160-164). Copying fees are updated January 1st of each year.

| **2012 PA Patient Fees** | |
|---|---|
| Amount charged per page for pages 1-20 | $ 1.39 |
| Amount charged per page for pages 21-60 | $ 1.03 |
| Amount charged per page for pages 61-end | $ 0.34 |

In addition to the amounts listed previously, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records.

TJUH will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by relevant Federal law.

TJUH will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information is not maintained on site. If TJUH is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

TJUH may deny this request under limited circumstances as provided for under federal law. TJUH will notify you if it denies your request to access or obtain a copy of the requested information. If TJUH denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the TJUH Privacy Officer at the following address:

Thomas Jefferson University Hospitals, Inc.
Privacy Officer
111 South 11th St.
Philadelphia, PA 19107