Patient Label (Name and Medical Record #)

0049211

ALBERT EINSTEIN HEALTHCARE NETWORK
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

☐ AEMC ☐ Ctr One ☐ GCHS ☐ MossRehab ☐ Willowcrest
☐ Other _____

I _____ authorize
Patient/Parent/Legal Guardian/Legal Representative

_____
(Name of institution/physician)

TO RELEASE INFORMATION TO ALBERT EINSTEIN HEALTHCARE NETWORK, TO THE ATTENTION OF

_____

Information Regarding Patient's Records to Be Released:

Patient's Name: _____ Date of Birth: _____

Address: _____

City, State: _____ Zip Code: _____ Telephone#: _____

INFORMATION TO BE RELEASED: (Must be Specific)
Copies of medical and/or psychiatric information from the health care record(s) pertaining to the hospitalization(s)/treatment(s) of:

Specify Dates of Treatment: _____ _____

_____ _____

_____

PURPOSE OR NEED FOR THE DISCLOSURE IS CONTINUED CARE.

_____

INFORMATION TO BE RELEASED:

☐ Designated Record Set/ Abstract	☐ Discharge/Clinical Summary	☐ Immunization Record
☐ Operative Procedure Report	☐ Consultation Report(s)	☐ History & Physical Report
☐ Laboratory Report	☐ Pathology Report	☐ Radiology Report
☐ Emergency Record	☐ Other _____	

☐ Entire Medical Record for Visit(s) specified above

EXPIRATION DATE: _____
Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication to the Albert Einstein Healthcare Network and/or that my consent expires under the circumstances above.

_____ _____
Patient's Signature Date of Authorization

_____ _____
Signature of Parent/Legal Guardian/Legal Representative Date of Authorization

_____ _____
Witnessed By Date

Telephone Number: _____ _____
Home Work