Penn Medicine
Lancaster General Hospital
Lancaster General Health

Authorization for Release

Patient Name: ______________________________

MRN: ______________________________

Date of Birth: ______________________________

Complete above information or attach patient label to each page.

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). ☐ Verbal Authorization

The information to be released is:

☐ Radiology Imaging Reports ☐ Discharge Summary ☐ Labs ☐ Pathology Reports
☐ Review Records ☐ Operative Report ☐ Emergency/Trauma Record ☐ Immunization Record
☐ Complete Medical Record ☐ PT/OT ☐ Other____________________
☐ Abstract of Medical Record (H&P, Discharge Summary, Diagnostic Test Results, Consultations Reports, Operative and Procedure Reports, Pathology Reports, EKG's and Labs)

With the Date(s) of Service of: ______________________________

I would like to receive this information via: ☐ Paper ☐ CD ☐ Secure Email

I understand the following:

- I may revoke authorization in writing at any time, 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).
- Lancaster General Health may receive compensation for medical record copying in accordance with PA law, §42 Pa.C.S. 6152
- I understand this authorization expires in 90 days unless otherwise specified, not to exceed 1 year from date of signature______________________________

______________________________ __________ __________
Signature of Patient or Authorized Representative Date Time

____
Printed Name of Patient

______________________________ __________ __________
Signature of Witness Date Time

____
Printed Name of Witness

______________________________ __________ __________
Signature of Witness Date Time

____
Printed Name of Witness

______________________________ ______________________________
Relationship to Patient Title/ Department

Identification Verified ☐ Driver's License ☐ Employee Identification ☐ Student Identification ☐ Other____________________

– For office use only –

Name of person processing request ____________________ Number of pages sent________ Date completed__________

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