authorize: Abington Memorial Hospital to release information from the record of:		p Otiloi		specify	
Patient Name		Birth Date		MRN	_ as described below
r attent warne		Dirtii Date		WILKIN	
o:Recipient of Protected Health	h Information		Phone		Fax
Recipient di Fiotected nealti	Timornation		Filone		FdX
Street		Cit	у	State	Zip Code
Please provide the patient's address (if diffe	erent from above	information) & phon	e number b	elow:	
Pat	tient Address			Patier	nt Phone Number
Records are requested for the purpose of: Please check one)		re/Medical Facility	☐ Legal	Personal Use	
Parts 1 and 2 must be completed to properly	y identify the reco	ords to be released.			
. Type of records to be released and date(s) of	•				
☐ Inpatient - Dates:		☐ Emergency Dept □	Dates:		
Same Day Surgery - Dates:		Outpatient Testing -	Dates:		
The following information will be released with	h your electronic vi	isit summary:			
Center Records, Labs, Radiology Reports, Cardiology Reports and Consults) Medication Lists	☐ History & F☐ Operative/I☐ Pathology☐ Nurses Not☐ Physician ☐ Discharge	Procedure Report Report/Slides tes Orders	[[[Physician Progress Psychiatric Evaluati Radiology Report Images on CD Other: ENTIRE RECORD	on
IIV and Mental Health information contained inless otherwise indicated. DO NOT	d in the parts of tl RELEASE: H			be released through Drug & Al	
understand that this Authorization is effective for exceed one year from the date of signature. I understoerson I authorized above to release the information f applicable, specify other expiration date/even	tand that I have the ri n. See side two of th	ght to revoke this author	ization at any	time by sending a writ	ten request to the entity
X					
SIGNATURE OF PATIEN	Т		TIME		DATE
SIGNATURE OF RESPONSIBLE	E PARTY		TIME		DATE
Relationship to Patient: Patient is:	t □ Disabled	☐ Deceased			
	_		eased/Short	Cert ☐ Power of A	ttorney for Healthcare
.egal Authority: Custodial Parent Legal					
_egal Authority: ☐ Custodial Parent ☐ Legal	SS		TIME		DATE



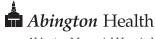
Abington Memorial Hospital Lansdale Hospital

> **AUTHORIZATION FOR RELEASE OF** PROTECTED HEALTH INFORMATION

Additional Patients Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Abington Health and its staff/employees have no responsibility or liability as a result of an redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- AHS cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- In accordance with 35 P.S. §7607 (e) pertaining to HIV-Related Information, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

I am entitled to a copy of this completed Authorization for



Abington Memorial Hospital Lansdale Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION