



MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Abstract 1: INPATIENT Medical Records (Up to 2 years old):

Provides Consult, Diagnostic Test Results, Emergency Department & Discharge Summaries, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Lab reports

Abstract 2: OUTPATIENT Medical Records (Up to 2 years old):

Provides Consult, Diagnostic Test Results, Emergency Department, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Outpatient Letter, Outpatient Clinic Notes, Lab reports.

Abstract 3: Only Diagnostic Test Result(s) (Up to 2 years old):

For example, Radiology, EEG, EKG, Cardiology Studies, Pathology, Pulmonary Studies
(specify Type of Test & Date) _____

Other:

- Discharge Summary(ies) Reports
- History & Physical Reports
- Laboratory Results
- Serial #/Product ID # for implanted devices
- Other **(please specify what document and date of services)** _____
- Outpatient Letters/Notes Reports
- Daily Progress Notes Reports
- Operative Report, Procedure Reports
- Radiology Image(s) – specify type and date

Please contact us with any questions or concerns at 717-531-8055

V. Patient or Representative Signature:

This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form, to the attention of the Director, Health Information Management. If not previously revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at Penn State Health. Neither our treatment nor your payment is conditioned upon your signature on this form.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

Signature of Patient or Representative

Date/Time

Relationship if signed by other than Patient

ORAL AUTHORIZATION (for persons unable to sign)

NOT Applicable to HIV-related Information or Drug & Alcohol Treatment Information

I witness that the patient/parent/legal guardian understood the nature of this release and freely gave their oral authorization (Two Witnesses are required)

Witness # 1

Date/Time

Witness # 2

Date/Time

Information Released by

Date/Time

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.

This document authorizes release of information entered into my medical record prior to or within 12 months after the date of my signature

PLEASE RETURN THIS FORM IMMEDIATELY TO HEALTH INFORMATION MANAGEMENT @ 717-531-5068

Note to recipient of 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.