Lehigh Valley Health Network

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Consent for Release of Protected Health Information

Section 1: Patient Information

PATIENT NAME		SOCIAL SECURITY NO.		DATE OF BIRTH
PATIENT ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

Section 2: Location(s) of Care

☐ Hospital * ☐ LVPG Physician Office ☐ Hospice ☐ Home Health
☐ Outpatient Clinic, Satellite location, or specified site ☐ Other Health Care Facility

Address Of LVPG Physician Office, Hospital Clinic, Satellite location(s), or Other Health Care Facility where you received care:

*Includes Cedar Crest, Muhlenberg and 17th and Chew Hospital locations.

Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self:

Address: Fax#:

For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance Purposes

☐ Legal Purposes ☐ Personal Access ☐ Other: _____

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Specific Information To Be Released

The information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

☐ Record Summary*	☐ Discharge Summary	☐ Physician Orders
☐ Office Notes/Visit Notes	☐ Operations Report	☐ Imaging Films (X-rays, Scans, CD)
☐ Immunizations	☐ Pathology Reports	☐ Photographs
☐ Disability/FMLA Form	☐ Consultation Reports	☐ Itemized Bills
☐ Medication List	☐ Laboratory Results	☐ Catheterization Lab
☐ Problem List	☐ Imaging Reports	☐ Entire Record (includes records from other facilities)
☐ Emergency Room Record	☐ EKG, EEG, Stress Tests	
☐ History & Physical Exams		

☐ Other (specify)_____

☐ **Exception:** I do not give permission to release {specify): _____

* For explanation of Record Summary, see Instructions for Completion.

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Section 5: Special Authorizations For Mental Health, Drug and Alcohol and HIV Records

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical record may contain "protected information" related to the following categories. My signature next to these items acknowledges my awareness and my authorization to release "protected information" in the record.

_____ Signature — Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider. (Confidential Alcohol and Drug Abuse Patient Information 42 C.F.R. Part II)

_____ Signature — Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician/provider. (PA Mental Health Procedure Act).

_____ Signature — HIV related information, if HIV-related tests were ordered by my physician/provider. (Confidentiality of HIV-Related Information Act, PA Law Act 148).

Information is being disclosed from records whose confidentiality is protected by Federal Law [42 C.F.R. Part II] and PA State Statutes [Title 55 Pa. Code 5100.32 and 5100.34 (a) and (b) and DAACA, 71 P.S. 1690.108 (b) & (c)].

Section 6: Authorization Signatures

AUTHORIZATION SIGNATURES

I understand that in order to process this request for the reproduction of medical record information on a timely basis, Lehigh Valley Health Network may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I do not have to sign this form in order to receive treatment at Lehigh Valley Health Network. **Even though the consent for release of information is valid for 90 days** I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that any action that has already been taken as authorized by this form will remain in force in order to achieve the purposes for which it is given. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Date Consent Expires:_____

Patient Signature:_____ Date Signed:_____

Signature of Parent/Legal Guardian/Authorized Representative:_____

Printed Name of Parent/Legal Guardian/Authorized Representative:_____

Unable to sign because:_____

Witness signature:_____

☐ Attached is a copy of the appropriate legal document, which proved authority to act on behalf of the patient.

CONTACT INFORMATION, MAILING/FAXING INSTRUCTIONS:

Mail/fax the completed form to the appropriate LVHN location or other facility where you received care as follows:

Hospital, (Inpatient and Outpatient Visits) Records:
Lehigh Valley Health Network - Attn. Release of Information
Cedar Crest and 1-78 Box 689
Allentown, PA 18105-1556
Phone: 610-402-8240 Mon.-Fri. 8:30AM to 4:00PM
Fax: 484-884-3824

Home Care and Hospice Records:
2024 Lehigh Street, Allentown, PA 18103
Phone: 610-402-7800
Fax: 610-402-7921

LVPG Physician Office Records and Satellite Locations:
Mail or fax to the physician office or satellite location where you received care. Please see http://www.lvpg.org for a listing of LVPG physician practice locations. Please see http://lvhn.org for a listing of satellite locations.

Other Facility:

_____

_____

_____

For office use only:

MRN#:_____ Encounter#:_____

Received: _____ Initial and Date ID Confirmed: _____ Initial and Date Completed: _____ Initial and Date