



- Allentown Campus
1736 Hamilton Street
Allentown, PA 18104
610-770-8590 Fax 610-770-8449
- Bethlehem Campus
801 Ostrum Street
Bethlehem, PA 18015
610-954-4719 Fax 610-954-4724

- Miners Memorial Campus
360 West Ruddle Street
Coaldale, PA 18218
570-645-8170 Fax 570-645-8373
- Quakertown Campus
1021 Park Avenue
Quakertown, PA 18951
215-538-4694 Fax 215-529-5299

MEDICAL INFORMATION RELEASE

Encounter number _____ Medical Record Number _____

PATIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
PATIENT ADDRESS		PHONE NUMBER

I authorize: _____ to release my Medical Records to: _____

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY
ATTENTION
ADDRESS AND/OR FAX #
FOR THE PURPOSE OF

information from within the Hospital records relating to my identity, diagnosis, prognosis or treatment.

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below as exception.
I also understand that my record may contain:

- AIDS/HIV-related information, if AIDS/HIV-related tests were ordered by my physician; Confidentiality of HIV-Related Information Act, PA Law Act 148.
- Mental Health information, if mental health treatment was given by my physician; PA Mental Health Procedure Act
- drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician. Drug & Alcohol Abuse Control Act 42 CFR Part 2

Date(s) of Service _____

The information to be released is:

<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Trauma Records
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Vascular Studies
<input type="checkbox"/> d/c Planning	<input type="checkbox"/> Onsite Review	<input type="checkbox"/> Verbal Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	<input type="checkbox"/> X-Ray Report
<input type="checkbox"/> EKG, EEG, Stress, ECHO	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Other (Please specify)
<input type="checkbox"/> Emergency Dept Records	<input type="checkbox"/> Psychiatric Evaluation	
<input type="checkbox"/> Face Sheet/Demographic Sheet		
<input type="checkbox"/> Films		

EXCEPTION: I do not give permission to release (please specify): _____

I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that my protected health information may be disclosed by the provider for patient care purposes.

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 action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given unless revoked by me.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

Patient's Signature/Date

Witness to Signature/Date

Signature of Authorized Person/Date

Witness to Signature/Date

Relationship: _____

Unable to sign because: _____



PATIENT Received Refused a copy of this form

Information released to: _____ Date _____

MEDICAL INFORMATION RELEASE

White - Chart Copy
Yellow - Patient Copy