



- Allentown and Bethlehem Campuses
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 _____
Date/Time Request Received _____

PATIENT NAME	DATE OF BIRTH
PATIENT ADDRESS	PHONE NUMBER

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

Is patient a minor? Yes No

If yes, are there any legal restrictions of your authority to act on behalf of the minor? Yes No

If yes, Legal documentation provided Yes No

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY _____

ATTENTION _____

ADDRESS AND/OR FAX # / PHONE # _____

FOR THE PURPOSE OF _____

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 _____

- | | |
|---|--|
| <input type="checkbox"/> Consultation Report
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> EKG, EEG, Stress, ECHO
<input type="checkbox"/> Emergency Dept Records
<input type="checkbox"/> Face Sheet/Demographics Sheet
<input type="checkbox"/> Films/CD
<input type="checkbox"/> History & Physical
<input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Operative Report
<input type="checkbox"/> X-Ray Report/CVL Report
<input type="checkbox"/> Other _____

_____ |
|---|--|

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 acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

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

Patient Identification

Photo I.D.

Other _____

POA Provided

Signature of Authorized Person/Date

Relationship: _____

Unable to sign because: _____



PATIENT Received Refused a copy of this form

Information released to: _____ Date/Time: _____

MEDICAL INFORMATION RELEASE

White - Chart Copy
Yellow - Patient Copy