Excellence Every Day.

One Hospital Drive Lewisburg, PA 17837 570.522.2000

www.evanhospital.com



Authorization for Release of Medical Record Information

Instructions for Completion

Follow these instructions for completing the form to request release of your medical record information.

Completion of this form is also required to obtain access to your personal medical information.

Failure to correctly complete this form may result in a delay in processing your request.

A patient access fee may apply.

- Enter the full patient name (last name, first name, and middle initial) and date of birth. Please include phone number where you can be reached if there are any questions related to your request.
- In the next section enter the name and address of the hospital, doctor, company, or person to whom the information will be released.
- If you are requesting access to your own personal medical information, please list your own name and address in this section.
- Check the box to indicate the specific information to be released and specify the date of service.
- Check the box that best describes the purpose of your request.
- If you have had testing, diagnosis, or treatment related to HIV/AIDS, alcohol/ drug abuse, or mental health, please read carefully the section that addresses the release of these types of information.
- The patient, parent, or legal representative must date and sign the form.
- The patient must be 18 years old or a legally emancipated minor to sign the authorization.
- If the form is signed by someone other than the patient, specify the signer's relationship to the patient on the next line.

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- After signing the authorization, a second individual should sign as a witness to your signature. Anyone can sign as a witness.
- If the individual signing the authorization form is a guardian, executor of an estate, or power of attorney for the patient, that person must submit a copy of the appropriate legal document which proves authority to act on behalf of the patient.
- If the patient is deceased, the executor of the estate must write on the authorization form "ESTATE" OR "NO ESTATE." If there is no estate, the death certificate must be submitted. The next of kin will need to sign the authorization. If there is an estate, a copy of the short certificate must be submitted. The executor of the estate must sign the authorization.
- Per HIPAA guidelines please keep a copy of your completed form.

Mailing Instructions

Mailing address:

Evangelical Community Hospital Health Information Services Release of Information One Hospital Drive Lewisburg, PA 17837

- FAX # 570-768-3930
- Scan and e-mail to <u>ROITeam@evanhospital.com</u> (this e-mail is not secure or encrypted)

Other Information

- It takes approximately 10 business days to release your medical information.
- Evangelical Community Hospital works with a contracted medical record copy service MRO -Medical Records Online. You may receive correspondence from MRO.
- Any questions or concerns, please call 570-522-2572.



One Hospital Drive, Lewisburg, PA 17837 Health Information Services – Fax# 570-768-3930 Telephone# 570-522-2572

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	Dat	e of birth:	M.R. #
Patient's Phone #:			
Authorization to Release Information I hereby authorize Evangelical Community Hos	spital to release protected healt	h information about me to:	:
Name:			
Address:			
Street	City	State	Zip code
Specific information to be released: (specify	y type of studies and specify da	ites of service)	
☐ Emergency Service Record		perative Report	
☐ Lab results X-ray results	⊔ Ра П Со	athology Report onsultation Report	
☐ History & Physical		ntire Record	
☐ Discharge Summary	Ot	her (describe)	
Purpose for the release of information: □ □ At the request of the patient or the patient's □ Other (describe):	legal representation for person		ourpose
,			
The requested medical record may include transmitted disease, acquired immunodefic virus (HIV). This information will be release DO NOT RELEASE information related to (present the property of the property o	ciency syndrome (AIDS), AIDS ed through this authorization	S related complex (ARC) unless otherwise indicate	and/or human immunodeficiency ted below.
 I understand that to process this request f Hospital may utilize a contracted medical I understand that this consent is revocable I understand that this consent will expire s I understand that once the information is of protected by federal privacy laws or regulated understand that if this authorization is for may involve direct or indirect remuneration I understand that I have the right to access Hospital. I understand that authorizing the disclauthorization except if my treatment is health care information for disclosure 	record copy service. by me, in writing, at any time of six months after the date of sign disclosed, it may be redisclosed ations. r Evangelical Community Hospin from a third party. s, review, and copy any information ideas related to research or health.	except to the extent that it lature or at the end of any I by the recipient and the intal to use or disclose my intation, which may be disclose this intified above is voluntary the care services provide	has been acted upon. applicable research project. Information may not continue to be Information for marketing purposes it sed by Evangelical Community y. I may refuse to sign this d solely for creating protected
Date of Signature	Signature of patient,	parent, or legal patient r	epresentative
Expiration date (6 months from date of signature)	Relationship to patie	nt if signed by legal repr	<u>esen</u> tative
	Witness to Signature	 }	

*The patient must be 18 years of age or a legally emancipated minor to sign this authorization except inpatient mental health information or drug and alcohol treatment records which can be authorized for release by a patient 14 years of age or older.

Rev: 01/04/2018