**HIPAA Authorization Form for Release of Medical Record Information**

**In the State of Pennsylvania, the physician who creates the patient’s medical records is the owner of those records. Current Pennsylvania Law states that a PHOTOCOPY of the medical record may be released to the patient or the patient’s representative upon proper request within a reasonable period of time. “Proper request” means a request in writing, and the form below may be used for that purpose. Please note that the law allows the physician a “Reasonable Period of Time” to comply with your request. It also permits the office to charge a Reasonable Fee for preparing the copy.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_

I hereby authorize **Greencastle Family Practice, P.C.** to use or disclose the protected health information for the above-named patient as described below.

**The following person, physician, group or entity may receive disclosure of protected health information for the above-named patient:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_Zip Code:\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of Records to be sent:**

Most recent two (2) years

Specific dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Medical Record

Specific Result/Consult Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unless you sign here**, **NO** information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD, will be disclosed.

**\*One signature required here\***

**YES**, disclose this information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NO**, do **NOT** disclose this information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations. This authorization will expire in one (1) year after the date on this request.

I may revoke this authorization by notifying **Greencastle Family Practice, P.C.** in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above-named patient on whether or not I sign the authorization.

**Reason for request**

My personal use

Further medical treatment

Insurance eligibility or benefits

Eligibility for disability benefits

Legal investigation or action

Transfer of Care

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient if 18 years of age or older\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian for minor child or POA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_