**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.**

**The information in this authorization is confidential and protected by Federal and State law from unauthorized use of disclosure.**

**(Please use black pen only)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

**Parent /Patient Name**

hereby authorize:

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

**(Physician, Facility Name & Address)**

to release to **Greencastle Family Practice, P.C.** information from the medical record of:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_

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

**Medical Information to be released:**

Complete Records

Last two (2) years

Specific Records/Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

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

**Please note, you may be charged a fee from the Physician/Facility releasing your medical records.**

**PLEASE ALLOW 2 WEEKS FOR PROCESSING**

I certify that I understand the contents of the form. This consent begins on the date of signature and is valid for a period of one year. Pennsylvania law prohibits Greencastle Family Practice, P.C. from making further disclosure of information unless written authorization for further disclosure is expressly permitted from the person to whom it pertains or is otherwise permitted by law. General authorization is not sufficient for this purpose.