

**AUTHORIZATION TO
RELEASE
MEDICAL INFORMATION
FEE MAY APPLY**

Patient name: _____
 Address: _____
 City, State, Zip: _____
 Date of birth: _____
 Medical record number: _____
 Phone number: _____

This form is used by all provider entities of the Geisinger Health (which is not a provider entity) including Geisinger Medical Center (all campuses), Geisinger Wyoming Valley Medical Center (all campuses), Geisinger Clinic (all sites), Geisinger Community Medical Center (all campuses), Geisinger Bloomsburg Hospital, Geisinger Lewistown Hospital, Geisinger Holy Spirit Hospital (all campuses), Geisinger Holy Spirit Medical Group (all sites), Geisinger Jersey Shore Hospital, and all other provider entities as outlined in the Geisinger Notice of Privacy Practices **but excluding** Marworth, and Geisinger Community Health Services.

I am requesting records from the following Geisinger entities:

All Sites Specific Clinic(s) or Hospital(s): _____

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

Name of hospital, company, or person to whom the information will be released to: RECORDS DEPOSITION SERVICE, INC.

Complete address: PO BOX 5054 SOUTHFIELD, MI 48086-5054

Telephone number: 248-357-3330 Fax number: 248-357-3337 Email address: REQUESTS@RECDEP.COM

***I am requesting that the information be produced (choose one):** Paper copies Fax Download to Email CD

***For the purpose of:** continuation of medical treatment payment of bill Worker's Compensation education

legal purposes insurance purposes at the request of the patient or the patient's legal representative

Other (specify): _____

*The information to be released will cover the **time period** from ____/____/____ to ____/____/____. ("present" equals date of signature)

***SPECIFIC INFORMATION TO RELEASE:**

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> EEG, EKG, Stress Test | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Emergency Dept. Notes | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Medications | <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Itemized Bills |
| <input type="checkbox"/> Other (specify): _____ | | | |

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the Geisinger Privacy Office immediately at systemprivacyoffice@geisinger.edu or 570-271-7360 if I wish to revoke this authorization. I also understand that this consent will expire six months after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party

SPECIAL AUTHORIZATION (IF APPLICABLE)

Patient initials **Parent/Guardian initials** **If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.**

_____(initials) _____(initials) My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released.

_____(initials) _____(initials) My evaluation, testing, diagnosis or treatment concerning my inpatient or involuntary mental health/rehabilitation treatment may be released.

_____(initials) _____(initials) My testing, diagnosis or treatment for HIV/AIDS may be released.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time: _____ **Patient Signature:** _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: _____

Date/Time: _____ **Signature:** _____
(Parent/legal or personal representative)

Description of personal representative's authority to act for the patient: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT*****