Coordinated Health

Mailing Address: Medical Records Department, 3435 Winchester Road, 2nd Floor, Allentown, PA 18104

Medical Record Department Phone Number: 610-861-8080 x36099

Fax Number: 610-841-5834

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________ Previous Name: ____________________

Address: ____________________ Date of Birth: ____________________

Date records needed by: ____________________ Phone: ____________________

I authorize Coordinated Health to release healthcare information of the patient above to:

Name: ____________________ Fax: ____________________

Address: ____________________

City: __________ State: ______ Zip Code: _______ Phone: ____________________

I am requesting the following:

□ Disability/FMLA Form □ Medical Record (paper) □ Medical Record (Electronic/CD-not encrypted)

I would like to receive the item above via:

□ Mail (to above address) □ Fax (to above number) □ Pick up at CH location: ______________

Records are requested for the purpose of:

□ Personal use □ Legal □ 2nd opinion/Medical Care □ Other:____________________

Location of facility for records requested:

□ CH Allentown Hospital □ CH Bethlehem Hospital □ Other CH facility ____________________

This authorization is limited to the following dates of treatment/service:

FROM____________________ TO____________________ (Dates MUST be filled in)

Information to be released (for medical record requests only):

□ **Record summary***	□ Operative Reports	□ Imaging Reports (x-ray, MRI, etc.)	□ Imaging films on CD (Note: CD's are not encrypted)
□ Physician Office Notes	□ Laboratory Results	□ EKG, EEG, Stress test	
□ Gynecological Records	□ Therapy Notes (PT/OT)	□ Entire Record	
□ Exception: I do not give permission to release (specify): ____________________			

*Record Summary includes key documents, such as: history and physical, recent test results, operative reports, discharge summaries, consultations, problem list, medication list, and recent office visits routinely provided to physicians for continuing care. Typically includes most recent 2 years of records.

Attention patient: Please complete this section:

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/ HIV, psychiatric illness or drug/alcohol abuse. Please check the appropriate boxes to indicate understanding:

-AIDS/HIV related information	□ No, do **NOT** disclose	□ Yes, disclose
-Mental Health information *(Excludes psychotherapy notes, separate consent required)*	□ No, do **NOT** disclose	□ Yes, disclose
-Drug/alcohol information	□ No, do **NOT** disclose	□ Yes, disclose

I hereby authorize Coordinated Health and its entities to disclose the health information as described above. This authorization is valid for 6 months from the date of signature of this request. I understand that: 1) this authorization may be revoked by me at any time by written notification to this facility, except to the extent that action has been taken in reliance upon this authorization; 2) Information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule; 3) Coordinated Health may not condition my treatment based upon whether or not I sign this authorization; **4) I understand that I will receive a copy of this authorization.** Please be aware that health care facilities are authorized by state & federal law to charge for the reproduction of medical records and that charges may be associated with this request. Requestors will be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Patient Signature: ____________________ Date: __________

Authorized Representative Signature: ____________________ Date: __________

□ Parent/Legal Guardian □ Power of Attorney □ Next of Kin of Deceased □ Estate Executor

□ Attached is a copy of the appropriate legal document, which proves authority to act on behalf of the patient.

This form must be completed in its entirety in order for it to be valid. Invalid forms will not be processed

For Internal Use: Date Received: ______________ Date Promised: ______________