**Holy Spirit Hospital - Health Information Services Department (Medical Records)**
**503 N. 21st Street – Camp Hill, PA – 17011**
**Phone: (717) 763-2660/2659 Fax: (717) 763-2920**

# AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

1)

| | |
|---|---|
| ________________________________ | ______________ |
| **Patient's Name (PRINT)** | **Patient's Date of Birth** |
| ________________________________ | ______________ |
| **Patient's Street Address** | **Social Security Number** |
| ________________________________ | (_____)______________ |
| **City, State, Zip Code** | **Phone Number** |

I, the undersigned, hereby authorize Holy Spirit Health System to **release** copies of medical records to:

2)

| | |
|---|---|
| ________________________________ | (_____)______________ |
| **Name of Person or Agency** | **Phone Number** |
| ________________________________ | (_____)______________ |
| **Address City, State, Zip Code** | **Fax Number** |

3) **The purpose or need for such information is** ____________________________________

4) **This request is concerning my treatment beginning (date)__________ up through (date)_________**

5) **Please check information to be received. The medical records to be received may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, or AIDS/HIV information. This information will only be received if you check the applicable box below.**

( ) Abstract (face sheet, summary of discharge, operative note, consult, lab, history/physical, x-ray, pathology)
( ) Admission History and Physical
( ) Consultation Reports
( ) Discharge Summaries
( ) Emergency Room Records
( ) Radiology/Nuclear Medicine Reports
( ) Operative Reports
( ) Pathology Reports

( ) Outpatient Surgery Records
( ) Physical/Occupational/Speech Therapy Records
( ) Cardiopulmonary, EKG, EEG Reports
( ) Laboratory Results
( ) Pulmonary Function Records
☐ Mental Health/Psychiatry/Psychotherapy Records
☐ AIDS/HIV Results
☐ Alcohol/Detox/Drug Abuse Records
( ) Billing Records
( ) Other__________________________

6) ______________________________________ ______________________________

**Signature of Patient or Personal Representative** **Date** **Relationship to Patient/ Bans of Authority**

______________________________________ ______________________________

**Witness** **Date** **Expiration date (May leave blank)**

**THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.**
**This authorization will expire within one year unless otherwise indicated**. This consent may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the Holy Spirit Health System Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this and the information is not authorized without specific consent of the patient or authorized representative.

**Please note: Photo Id may be requested at the time of release. Per Pennsylvania State law, a copying fee may be assessed for these copies if they are not being directly sent to a continuing care provider**

7)

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| ____________ | ____________ | ________________________ | ______ |
| MR # | Date Completed | Completed By | # pages |