Philadelphia Hand to Shoulder Center

Individual Patient Authorization for the Release of Medical Records

You must complete this form in its entirety and sign & date where indicated.
Completed forms can be mailed to the physician's home office or faxed to the attention of the "Medical Records Staff" at Fax # 215-521-3002.

1. INDIVIDUAL PATIENT INFORMATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: ______________________________
Patient's Address: ______________________________
Patient's Address: ______________________________
Patient's Telephone Number: ______________________________
Patient's E-mail Address: ______________________________
Patient's Account Number: ______________________________
Patient's Social Security Number: ______________________________

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed.

____
____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected health information described above.

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Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

	Name	*Address*
1.		
2.		

Purpose of Disclosure (Check one):

☐ Changing Physicians ☐ Consultation/Second Opinion ☐ Continuing Care ☐ Legal
☐ School ☐ Insurance ☐ Workers Compensation ☐ Research
☐ Other (please specify):______________________________

3. ENDING THIS AUTHORIZATION

Select one of the following two choices*:

☐ This authorization will end on the following date: _________ Signature: ____________________
☐ This authorization will end when I elect, in writing, to revoke it. Signature: ____________________

* ***If no selection is made or if this section is incomplete, this authorization will automatically expire 6 months from the date the form was signed.***

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

(Continued on reverse side/2nd page)

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4. POTENTIAL FOR REDISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It is not possible for Philadelphia Hand to Shoulder Center to ensure the privacy of your information, once we disclose it in accordance with your authorization.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. FEES

I understand that I must pay a fee in advance, for the copying and mailing of the information that I have authorized use and disclosure of.

7. AUTHORIZATION

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form. I also understand that I may refuse to sign this authorization.

Signature: ______________________________ **Date:** ____________________

If this authorization is signed by a personal representative for the individual patient, complete the following:

Personal Representative's Name (print name): ______________________________

Personal Representative's Signature: ______________________________

Relationship to the Individual Patient: ______________________________

You must complete this form in its entirety and sign & date where indicated.
Completed forms can be mailed to the physician's home office or faxed to the attention of the "Medical Records Staff" at Fax # 215-521-3002.

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT, IF YOU REQUEST ONE.

FOR OFFICE USE ONLY

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

Date Request Filed: ____________________ By *(please print):* ____________________

Identification Presented: ____________________ Fee Collected: $____________________

Date request completed:____________________ By *(please print):* ____________________