Chestnut Hill Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Protected Health Information
Authorization for Release, Use, and Disclosure

Last Name _____ First Name _____ Date of Birth _____ MRN _____

Address _____ Phone _____ Email _____

I authorize _____ to release my Medical Records to: ☐ Me or ☐ Recipient:

Name of Authorized Person, Doctor, Hospital, Agency or Other _____ Phone _____

Address _____ Fax _____

ATTENTION PATIENT:
I understand and authorize the release of this information with the exceptions of: _____
If included in the medical record, this authorization includes the release of information protected by: Confidentiality of HIV-Related Information Act (AIDS, HIV-related information or testing), Mental Health Procedures Act (psychiatric disorders), Drug and Alcohol Abuse Control Act (drug and/or alcohol treatment) as permitted by law.

Information to be released: **Date(s) of Service:** _____

☐ Discharge Summary ☐ Operative Report ☐ PT/OT ☐ Radiology/Imaging Reports
☐ Emergency/Trauma Records ☐ Outpatient Clinic ☐ Radiology Images ☐ Review Records (by appointment)
☐ Labs ☐ Pathology Reports (not available through MyTowerHealth) ☐ Speech And Hearing
☐ Abstract of Medical records = H&P, Discharge Summary, Diagnostic Test Results, Problem List, Medications, Allergies and Procedure reports EKG's Labs
☐ Electronic Abstract = Discharge Summary, Diagnostic test Results, Problem List, Medication, Allergies and Procedure reports
☐ Other = _____
☐ Complete Medical Record ☐ Billing Record

Reason for Disclosure: ☐ Personal ☐ Further Medical Care ☐ Legal Investigation or Action ☐ Other: _____

☐ Out of Tower Health Medical Group to: _____

I would like to receive this information VIA: ☐ Paper ☐ CD ☐ Secure Email ☐ MyTowerHealth Patient Portal ☐ Other: _____
CD # _____

I understand the following: I may revoke authorization in writing at anytime; this revocation will not apply to information that has already been released in response to this authorization. The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization. I have the right to inspect or copy the health information to be used or disclosed as permitted by law. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable). Pottstown Hospital may receive compensation for medical record copying in accordance with PA Law, 42 Pa. C.S. §6152. I understand that this consent will expire 90 days from the date below or upon my death, whichever occurs earlier.

Signature of Patient or Authorized Representative _____ Date _____ Signature of Witness _____ Date _____

Printed Name of Patient _____ Printed Name of Witness _____

Relationship to Patient _____ Title/Department _____