



Protected Health Information Authorization for Release, Use, and Disclosure

Return your completed form to
Tower Health Medical Group Information Management
P.O. Box 16052
Reading, PA 19612-6052
Phone number 484-628-8252
or fax to 484-628-9777

Last Name	First Name	Date of Birth	MRN
Address		Phone	Email

I authorize **Tower Health Medical Group** _____ 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:** _____

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