



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

**Reason for Disclosure:**  Personal  Further Medical Care  Legal Investigation or Action  Other: \_\_\_\_\_

Out of St. Christopher's Pediatric Associates 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). St. Christopher's Pediatric Associates 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