Doylestown Hospital
595 West State Street Doylestown, PA 18901

Pick Up Date: _____

Pick Up Location: DH HWC

☐ **Emergency Dept.** Phone: 215-345-2109 Fax: 215-345-2058
☐ **Medical Records** Phone: 215- 345-2314 Fax: 215-489-7235
☐ **Radiology** Phone: 215-345-2599 Fax: 215-345-2403
☐ **Department_____Phone:_____Fax: _____**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name:_____Date of Birth: _____

Address: _____

Phone Number:_____Last 4 Digits of SS #:_____MR #:_____

Release Records to: _____

_____

Dates of Information to be released: _____

☐ Entire Record ☐ ECG/Cardiology Testing Results ☐ Medication List
☐ Consults ☐ ER Record ☐ Progress Notes
☐ Discharge Summary ☐ H&P ☐ Radiology Results
☐ Discharge Instructions ☐ Lab Results

Other: _____

These Records are needed:_____For personal use_____For continuation of care.

I understand that my rights as a patient include my knowing:

a. My medical record may contain information of a sensitive or extremely private nature, including, but not limited to a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.
b. I or my representative may revoke or modify this authorization at any time by writing to HIS of Doylestown Hospital except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking will only prevent future disclosure.
c. The hospital will not condition treatment, payment, enrollment or eligibility on the provisions of this authorization.
d. Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
e. I understand that I cannot be compelled to authorize release of any of my medical records. This

☐ authorization expires on:_____ ☐ This authorization has no expiration date.

_____ _____
Patient signature Date

If person signing is someone other than patient:

_____ _____
Signature Date

_____
Print Name

_____
Relationship to patient and authority to sign (i.e. legal guardian, Power of Attorney)

THIS FORM IS TO BE KEPT AS A PART OF THE PATIENT PERMANENT RECORD

Photo ID type and #: _____ Hospital Assoc. Signature: _____

Reviewed: 1/15, 6/17, 3/18
Revised: 8/11, 9/11, 10/13, 6/15, 9/20