Name:	Birthdate:
Address (Street):	Gender:
Address (City, State, Zip):	Student ID#:

Morris Health Services

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Record Request Addressee

I authorize Morris Health Services, 370 Lancaster Avenue, Haverford, PA 19041 to **receive / disclose** (circle one) information contained in my medical record **from / to** (circle one):	
Name:	
Organization:	
Address (Street):	
Address (City, State, Zip):	
Phone:	Fax:
Date(s) of Treatment:	

Information to be Received

☐ History & Physical	☐ Lab Reports	☐ Immunizations
☐ Consultation Report	☐ Diagnostic Imaging	☐ Itemize Bills
☐ Progress Notes	(XRAY, Cat Scan, Ultrasound, etc.)	☐ Other: ___________________________
☐ Clinical Notes		

Special Authorization (if applicable)

Patient Initials	**If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/ or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.**
	My evaluation, testing, diagnosis or treatment for alcoholism and/ or drug abuse or dependence may be released to the recipient noted on the signed authorization.
	My evaluation, testing, diagnosis or treatment concerning my mental health/ rehabilitation information may be released to the recipient noted on the signed authorization.
	My testing, diagnosis or treatment for HIV/ AIDS may be released to the recipient noted on this signed authorization.

Purpose of Releasing Information

☐ Continuation of Medical Treatment	☐ School/ Job Purposes	☐ Insurance Purposes
☐ Payment of Bill	☐ Legal Purposes	☐ Other: ____________________

Record Release Fee

Health Services will charge for copying records in accordance with Pennsylvania law, as applicable ($20.00). **For a copy of your records, please send a $20.00 check made payable to Haverford College Health Services**. Check can be mailed or dropped off to Haverford College Health Services ATTN: Medical Records, 370 Lancaster Avenue, Haverford, PA 19041.

Signature to Disclose Release of Medical Information

____

Signature　　　　　　　　　　　　　　　　　Date

(Office Use Only) Release of Psychiatric Care Information

____

Signature of Staff

____

Printed Name of Staff Date Time

Second Staff Witness Signature

(Required only if patient **verbally** consents Release of Psychiatric Care Information)

____

Signature of Staff

____

Printed Name of Staff Date Time

Instructions for Completing The Authorization For Disclosure of Health Information

1. Please complete all sections of the Authorization for Disclosure of Health Information.
2. The patient or legally authorized representative must sign and date the form.
   Generally, only a patient may authorize release of their medical information.
   Exceptions to the rule are as follows:
   a. Authorizations of minors – If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.
   b. Emancipated minor is a minor under the age of 18, who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.
   c. A minor who has been diagnosed with a venereal disease, a substance abuse problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.
   d. Authorization after death – An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
   e. Authorization of the incompetent patient – If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.
   f. Signature of Staff – The staff obtaining signature requirement applies only to the release of psychiatric care information as specifically authorized by the patient. The hospital or records management staff person obtaining this authorization of the patient or legally authorized representative (either in writing as witnessed, or by verbal confirmation of written form) should sign, print name, date and time the form. A second witness is required to sign if the patient/ patient representative consents verbally. Please have the witness sign, print their name and include the date and time.

Morris Health Services reserves the right to request proof of representation.

The address to submit record requests:
Morris Health Services
370 Lancaster Avenue
Haverford, PA 19041

Any Ambulatory/ Office Visit Requests should be addressed to the individual Physician's Office

Please Note

1. Health Services will charge for copying records in accordance with Pennsylvania law, as applicable ($20.00).
2. Health Services will make reasonable efforts to comply with this requirement within thirty (30) days for information that is maintained or accessible on site.