BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
825 Old Lancaster Road ▪ Suite 320
Bryn Mawr, PA 19010
(610) 527-3800

PATIENT INFORMATION
(Please Print)

Patient Name: ______________________________________ Patient Address: ____

City: ____ State: _________ Zip Code: _______________________________

Date of Birth: ______/_______/________________________ SSN #: _____-____-________

REQUESTOR/RECIPIENT INFORMATION

I hereby authorize (complete name and address of facility you wish to have records release from):

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Please disclose the following protected health information to (complete address):

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_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____EMERGENCY REPORTS
_____HISTORY & PHYSICAL _____LABORATORY REPORTS _____OTHER
_____PROGRESS NOTES _____RADIOLOGY REPORTS
_____OPERATIVE NOTES _____ECG/EEG/CARDIAC CATH ___________________________

________ I do __________ I do not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychologic assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP

_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to Russ Militello, Privacy Officer. I understand that the revocation does not apply to information already released in response to this authorization.

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date:

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I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the Privacy Officer and request a copy of this authorization.

____ ____
Signature of Patient or Authorized Representative Date

____ ____
Description of Representatives Authority Signature of Witness
(Witness Signature Required)