BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

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):

_____

_____

_____

_____

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

EXTON FAMILY MEDICINE ph: 484-879-6992
fax:484-879-4476
495 THOMAS JONES WAY
SUITE 306
EXTON, PA 19341

_____DISCHARGE SUMMARY
_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____OPERATIVE NOTES

_____PATHOLOGY REPORTS
_____LABORATORY REPORTS
_____RADIOLOGY REPORTS
_____ECG/EEG/CARDIAC CATH

_____EMERGENCY REPORTS
_____OTHER
_____

_____ 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 _____TRANSFER CARE

_____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:

_____

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)