

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):

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

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> 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

Please allow 7-10 Business Days for Processing

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)