Bryn Mawr Medical Specialists Association
825 OLD LANCASTER ROAD SUITE 320
BRYN MAWR, PA 19010
610-527-3800 | (610) 672-6500 (fax)

PATIENT INFORMATION

(Please Print)

Patient Name: _____ Patient Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____

REQUESTOR/RECIPIENT INFORMATION

I hereby authorize Bryn Mawr Medical Specialists Association ("BMMSA") to release the following protected health information ("PHI") from my medical record:

BMMSA Physician(s)/Department(s):_____

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

_____ I do (initial) _____ I do not (initial) 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.

RECIPIENT: Please disclose the above selected PHI to the following person/entity ("Recipient")

Recipient Name: _____ Recipient Address: _____

City: _____ State: _____ Zip Code: _____

MANNER OF ACCESS: _____ FAX _____ _____MAIL (above address)

PURPOSE OF DISCLOSURE: _____REFERRAL TO SPECIALIST _____INSURANCE _____PERSONAL _____WORKERS COMP _____LEGAL INVESTIGATION _____DISABILITY DETERMINATION

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 Salvatore Filippello, our Chief Compliance and Privacy Officer. I understand that the revocation does not apply to information already released in response to this authorization.

EXPIRATION DATE: unless otherwise revoked, ***this authorization will expire 6 months from the date signed below or on the following date, whichever is sooner***: _____

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 (if not signed by Patient)