**825 OLD LANCASTER ROAD SUITE 320**
**BRYN MAWR, PA 19010**
**610-525-4151 | (610) 672-6500 (fax)**

## HIPAA COMPLIANT REQUEST FOR MEDICAL RECORDS

Patient Name (Please Print):_________________________________________ Date of Birth: ______/________/______________

Patient Address: ____________________________________ _______________________________________________________

City: _____________________ State: _________ Zip Code: ____________

### 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)**: _____ ALL Departments/Physicians _____ ________________________
List Department/Physicians

**Records to be Disclosed:**

_____Entire Medical Record (of selected Department/Physician) OR

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

__________ 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)

Revised 12/9/2024