PennState Health
Milton S. Hershey Medical Center

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Penn State Milton S. Hershey Medical Center, Health Information Services, Mail Code HU24, P.O. Box 850, Hershey, PA 17033-0850

Name of Patient: _____

Date of Birth: _____ Phone: _____

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.
The information being disclosed may include: HIV/AIDS, Drug/Alcohol Abuse & Mental Health data.
This document authorizes release of information entered into my medical record prior to or within 12 months after the date of my signature.

☐ **Release Medical Records To** ☐ **Receive Medical Records From**

_____
(Name of Authorized Person, Agency, Institution or other)

_____
Street Address

_____
City State Zip Code

Format in which you would like to release or receive medical records information:

☐ Medical Record on Paper ☐ Medical Record on CD *(Fax this form immediately to Health Information Services at 717/531-5068.)*

☐ Radiology Images on CD ☐ Medical Records via Internet *Fax this form immediately to Health Information Services at 717/531-5068.* ***PLEASE ALSO COMPLETE the Electronic Record Delivery Request form****. This option only available for records going directly to patient or parent of minor/POA/legal guardian.*

Reason for Request:_____

_____

_____

Due to procedural and regulated steps involved with the process of release of information, costs are associated with compiling medical records and, therefore, there could be an associated fee incurred by you for requests for medical records. All fees are regulated by state and federal law and are updated by PA State Legislature annually. The fees listed below are effective January 1 - December 31, 2016:

Pages 1-5	No Charge
Pages 6-20	$1.46 per page
Pages 21-60	$1.08 per page
Pages 61-end	$0.36 per page
Microfilm/Microfiche	$2.16 per page

Plus applicable postage and tax

Please Complete Page Two

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MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

Please provide the ***type(s) of medical records*** information requested by checking the boxes and listing their ***dates of service below:***

(List dates of service here):

_____

_____

☐ **Abstract of INPATIENT Medical Records:**

Provides Consult, Diagnostic Test Results, Emergency Department & Discharge Summaries, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Lab Reports.

☐ **Abstract of OUTPATIENT Medical Records:**

Provides Consult, Diagnostic Test Results, Emergency Department, History and Physical, Medication Allergies, Medication List, Procedures, Pathology Report, Outpatient Letter, Outpatient Clinic Notes, Lab Reports.

☐ **Diagnostic Test Result(s)**

For example, EEG, EKG, Cardiology Studies, Pathology, Pulmonary Studies
(specify Type of Test & Date) _____

_____

_____

_____

(OR)

☐ **Other:**

- ☐ Discharge Summary(ies)
- ☐ History & Physical
- ☐ Laboratory Results
- ☐ Serial #/Product ID # for implanted devices
- ☐ Outpatient Letters/Notes
- ☐ Daily Progress Notes
- ☐ Operative Report, Procedure Report
- ☐ Other ***(please specify what document and date of service)*** _____

_____

_____

This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form, to the attention of the Director, Health Information Services. If not previously revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at Hershey Medical Center. Neither our treatment nor your payment is conditioned upon your signature on this form.

I Hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

_____ _____
Signature of Patient or Representative Date

_____
Relationship if signed by other than Patient

Note to recipient of information: This information has been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.