Lancaster Behavioral Health Hospital

Penn Medicine Lancaster General Health | UHS

333 Harrisburg Ave, Lancaster, PA 17603
Phone: 717-740-4172 Fax: 717-740-4063

(Affix patient label here)

Patient Name:

Med Rec #:

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORD INFORMATION

Patient Name: ________________________ Date of Birth: ________________________

Maiden / Prior Name(s): ________________________ Phone Number: ________________________

Current Address: ____

I hereby authorize LBHH, orally or in writing, to ☐ release my medical records to AND/OR ☐ obtain my medical records from:

Name: ________________________ Relationship / Organization: ________________________

Address: ____

Phone Number: ________________________ Secure Fax Number: ________________________

Dates of Service Requested: ____

Authorizing patient, parent or guardian <u>must initial documentation indicated for release</u>.

____ Transition of Care Pack (Aftercare Visit Summary, Adv. Directive Ack., Clinical Intake Assessment, D/C Crisis Safety Plan)
____ Pertinent Pack (Discharge Summary, H&P, Psychiatric Evaluation, Aftercare Visit Summary)

____ Discharge Summary
____ History & Physical/Neuro Examination
____ Nursing Assessment
____ Labs/Diagnostic Testing: ________________
____ Clinical Intake Assessment
____ Medical Reports / Consultations
____ Biopsychosocial Assessment
____ Psychiatric Evaluation
____ HIV Test Results / AIDS Records
____ Alcohol & Drug Abuse Treatment Records

____ Psychological Assessment / Testing: ________________
____ Educational Records: ________________
____ Medications: ________________
____ Multidisciplinary Treatment Plan: ________________
____ Progress Notes: ________________
____ Aftercare Visit Summary
____ Psychiatric Discharge Note
____ Verbal Communication: ________________
____ Physician's Orders: ________________
____ Other: ________________

I am requesting disclosure of my health information for the following purpose:

☐ Continuing Care ☐ Insurance ☐ Self ☐ Child Custody ☐ Disability Determination
☐ Legal Investigation ☐ Academic ☐ Other: ________________________

Do **<u>not</u>** release the following: ____

This Authorization will remain valid for 6 months unless another date or event is specified here: ________________________

*** THE ABOVE INFORMATION MUST BE COMPLETED IN FULL BEFORE SIGNING.**

I, the undersigned, hereby acknowledge that I have read this Authorization prior to its execution and fully understand the nature of the release.

Patient	**Date**	**Parent/Guardian AND Relationship** (if minor is under 14 years of age or if legal guardianship exists)	**Date**
Witness Signature / Credentials	**Date**		

The patient was unable to physically sign because ____.
Therefore, a verbal authorization was given by ____ on ________________ .
We, the undersigned, affirm that the patient understood the nature of the release and freely gave verbal consent.

Witness Signature / Credentials	Date	Witness Signature / Credentials	Date

This authorization is intended to allow Lancaster Behavioral Health Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, Pennsylvania Mental Health Procedures Act of 1976, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization in writing (or orally, if writing is not possible) at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations. You have the right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

Revocation Signature	Date/Time