**AUTHORIZATION FOR RELEASE OF INFORMATION**

# MARWORTH

**GEISINGER HEALTH SYSTEM[1]**

Patient Name:
Last Four of SSN#:
Date of Birth:

I hereby freely authorize an appropriate workforce member of Marworth to release information from my medical record to: _____
(name or title of the individual or name of organization to which disclosure is to be made)

Address: _____
(address of receiving party)

Telephone: _____FAX:_____

**How Much and What Kind of Information to be Disclosed/Released** – (Place an X by those items to be released)

| | | | |
|---|---|---|---|
| ____ Discharge summary | ____ Medications | ____ Treatment plans | ____ Progress in continuing care |
| ____ Integrated summary | ____ Lab, X-ray, EKG | ____ Continuing care plan | ____ FMLA/disability forms |
| ____ History & Physical | ____ PPD | ____ Prognosis | ____ Copy of Bill |
| ____ Biopsychosocial | ____ Orders | ____ Presence in treatment | ____ Family packet |
| ____ Consults | ____ Diagnosis | ____ Progress in treatment | ____ Other _____ |
| ____ Medication administration record | ____ Progress notes | ____ Nature of program | _____ |

**The information to be released will cover the time period from _____ to _____.**
**("present" equals date of signature)**

**Purpose of the Disclosure is For/To:**

| | |
|---|---|
| ___ Continuity of Care | ___ Settle Insurance Claim |
| ___ Discharge/Continuing Care Planning | ___ Keep Family/Significant Other Involved |
| ___ Assist with Legal Issues | ___ Keep Employer/School Involved |
| ___ Fill Out FMLA/Disability Forms | ___ Keep Referral Source Involved |
| ___ Application for Insurance | ___ Other _____ |

**Method of Releasing this Information:** ____ Telephone ____ Mail ____ Interview ____ Fax _____ e-secure email _____
Hand Delivered by: _____(name of person)

The consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payor. I will contact Marworth immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for Marworth, I may request such Notice of Privacy Practices for the ease of reference. Marworth may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party. **If not previously revoked, this authorization will expire 365 days after the date of my signature or on _____ (if other than 365 days).** The release of information is limited to the person or organization named above and will not be used for any other purpose than that stated.

## AUTHORIZATION SIGNATURES

_____ _____
Patient Signature Date Signed

_____ _____
Witness Signature Date Signed

**If patient is unable to sign authorization form because of physical condition or age, complete the following:** Patient is a minor or patient is unable to sign authorization because: _____

_____ _____
Parent/Legal or Personal Representative Signature Date Signed

_____ _____
Witness Signature Date Signed

"This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit 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 or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." **Protected by Pennsylvania and Federal regulations.**

**COPY OF COMPLETED AUTHORIZATION FORM MUST BE OFFERED TO PATIENT. PATIENT ACCEPTED/REFUSED (please circle).**

[1]Throughout this form the acronym "GHS" or the terms "System," "Geisinger" or "Geisinger Health System" shall refer to the entire Health Care System comprised of the Geisinger Health System Foundation (the "Foundation") as parent and all subsidiary corporate entities comprising the Health Care System.