

Einstein Healthcare Network Authorization to Obtain Protected Health Information

Patient Label (Name and Medical Record #)		
☐ Willowcrest ☐ Other	□ EMC □ CtrOne □ GCHS □ MossRv	-
	hab 🗆 Belmont	•

Authorization to Obtain Protected Health Information

Work Phone	Home Phone
Date	Witness
Date	Signature of Parent/Legal Guardian/Legal Representative
Date	Signature of Patient
authorization (except to the extent that action has been taken in rehance thereon) at anytime by written, cated communication to the Einstein Healthcare Network and/or that my consent expires under the circumstances above.	nzation (except to the extent that action has been to unication to the Einstein Healthcare Network and/or
Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this	176 and the Pennsylvania Confidentiality of HIV Relatiten consent unless otherwise provided for in the residence (1) month from the date of my signature. Undescome void ninety (90) days from the date of my signature.
I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures	rstand that my records are protected under the Heary act, P.I., 93-575, the Federal Alcohol and Drug Abus
(Specify date, event, or condition upon which this consent will expire unless revoked at an earlier date/time)	Expiration Date: $\frac{1}{(Specify\ date,\ event,\ or\ condition\ upon\ which is the property of the property of$
Report □ Other	Clinical Emergency
☐ Immunization Record ☐ Pathology Report ☐ Laboratory Report ☐ Radiology Report ☐ Operative Procedure	t(s)
	Information To Be Released:
d Care.	Purpose or Need for the Disclosure is Continued Care.
Copies of medical and/or psychiatric information from the health care record(s) pertaining to the hospitalization(s) treatment(s) of: Specify Dates:	Copies of medical and/or psychiatric information from the health can Specify Dates:
	Information to be Released (must be specific):
Work Phone:	Home Phone:
	Address:
Date of Birth:	Patient's Name:
Released:	Information Regarding Patient's Records to be Released:
k, to the αttention of	information to Einstein Healthcare Network, to the attention of
izeto release Name of Institution/Physician	Patient/Parent/Legal Guardian/Legal Representative

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