Form AD0020, Rev. 11/11

Lower Bucks Hospital
501 Bath Road • Bristol, PA 19007

* A D 0 0 2 0 *

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION



To be valid, all information below must be completed and the patient must date and sign in the space provided.
**PLEASE PRINT**

| **Patient's Name (when seen at Lower Bucks Hospital from which records are being requested)** First Middle Last | **Patient's Date of Birth: Month - Day - Year** |
|---|---|
| | **Patient's Social Security Number** |
| **Specific Health Record(s) Authorized for Disclosure** | |
| Date of Treatment / Type of Treatment / Visit | **Patient's Daytime Phone Number** |
| ☐ Admitted Overnight ☐ Seen in Emergency Dept & Released<br>☐ Same Day / Outpatient Surgery or Procedure<br>☐ Outpatient, department in which seen _____ | |

**Release To - I, the undersigned, authorize Lower Bucks Hospital to disclose the health information pertaining to the patient named above to the following Individual or organization:**

| NAME (person to receive information) | | ORGANIZATION (facility to receive information) | | |
|---|---|---|---|---|
| | | | | |
| ADDRESS | CITY | STATE | ZIP | TELEPHONE - INCLUDE AREA CODE |
| | | | | |

I understand that once the above information is disclosed (released) from Lower Bucks Hospital, it may be redisclosed (re-released) by that individual or organization and the information may not be protected by federal privacy laws or regulations.

**Type of Information** - The type of health information to be disclosed from Lower Bucks Hospital is as follows:

| | | | |
|---|---|---|---|
| ☐ Emergency Room Reports | ☐ Operative Reports | ☐ Cardiac Cath Reports | ☐ Medications |
| ☐ Admission Note | ☐ Endoscopy Reports | ☐ Radiology Reports | ☐ Entire Record |
| ☐ Discharge Summary | ☐ Pathology Reports | ☐ Radiology CD / Films / Paper | ☐ Abstract (summary) |
| ☐ History & Physical | ☐ Laboratory Reports | ☐ EKG Reports | ☐ _____ |
| ☐ Consultation Reports | ☐ Echocardiogram Report | ☐ Sleep Studies | ☐ _____ |

**Purpose** - The information for which I am authorizing disclosure will be used for the purpose of:
☐ medical care ☐ insurance ☐ legal ☐ personal

Please understand that this information is required by federal law and there may be specific information in the medical record(s) requested that cannot be released unless you do complete this field. (P.L 93-282, Title 42 HHS)
I understand that the information in my health record may include information relating to any one or more of the following:

(a) Sexually Transmitted Disease(s) (STD's)
(b) Acquired Immunodeficiency Syndrome (AIDS)
(c) Human Immunodeficiency Virus (HIV),
(d) Human Immunodeficiency Virus (HIV) testing & results,
(e) drug abuse and/or alcoholism,
(f) psychological or psychiatric impairments
(g) behavioral services
(h) mental health services

**Expiration** - This authorization will expire (a) on the following date - Mo _____ Day _____ Yr_____ or
(b) at the time of the following event (specify) _____

*If I do not specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed, below.*

**Revocation** - I understand that I have the right to revoke (cancel) this authorization at any time. I understand that if I revoke (cancel) this authorization, I must do so in writing and present my written revocation to the correspondence clerk or the director of the medical record department. I understand that the revocation (cancellation) will not apply to information that has already been released in response to this authorization. I understand that the revocation (cancellation) will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ PATIENT SIGNATURE
_____ DATE

_____ SIGNATURE RELATIVE / GUARDIAN / LEGAL REPRESENTATIVE

_____ RELATIONSHIP TO PATIENT

_____ WITNESS SIGNATURE
_____ DATE

_____ WITNESS SIGNATURE (2nd witness req'd or verbal consent)
_____ DATE

If patient is a minor or unable to sign, complete the following:
[ ] Patient is a minor, _____ years of age, or
[ ] Patient is unable to sign because, (complete "reason" below)

_____ Reason Patient is unable to sign