AUTHORIZATION FOR RELEASE OF INFORMATION

MARWORTH

GEISINGER HEALTH SYSTEM[1]

NAME:
SSN#:
DOB:

I HEREBY FREELY AUTHORIZE AN APPROPRIATE WORKFORCE MEMBER OF MARWORTH TO RELEASE

INFORMATION FROM MY MEDICAL RECORD TO: ____
(Person or organization receiving information)

Address: ____

Phone/Fax: ____

THE FOLLOWING INFORMATION – (Place an X by those items to be released)

___ Medical Discharge Summary
___ Counselor Discharge Summary
___ Physical
___ Biopsychosocial
___ Consultations
___ Progress in Treatment
___ Back to Work Letter
___ Family Packet
___ Presence in Treatment
___ Progress Notes
___ Treatment Plan
___ Continuing Care Plan
___ Progress in Continuing Care
___ Other __________________
___ Lab, X-Ray, EKG, and Audiogram
___ Diagnosis
___ Copy of Bill
___ Nature of Program
___ Prognosis

The information to be released will cover the time period from ____________________ to ___________________.
(MM/DD/YYYY) (MM/DD/YYYY)

THE PURPOSE OF THE DISCLOSURE IS FOR/TO:

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

THE METHOD OF RELEASING THIS INFORMATION IS:

___ Telephone Contact ___ Mail ___ Interview ___ Fax ___ Hand Delivered by: _________________________
(Name of Person)

This authorization is subject to revocation, in writing, at any time except to the extent that action has been taken in reliance thereon. 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. 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.

_______________________________________ _____________________
Patient's Signature Date Signed

_______________________________________ _____________________
Witness's 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 GIVEN TO PATIENT.

[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.