

# AUTHORIZATION FOR RELEASE OF INFORMATION

## MARWORTH

Doing business as Geisinger Marworth Treatment Center

Patient Name: \_\_\_\_\_

Last four of SS#: \_\_\_\_\_

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

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Discharge summary                | <input type="checkbox"/> Medications     | <input type="checkbox"/> Treatment plans       | <input type="checkbox"/> Progress in continuing care |
| <input type="checkbox"/> Integrated summary               | <input type="checkbox"/> Lab, X-ray, EKG | <input type="checkbox"/> Continuing care plan  | <input type="checkbox"/> FMLA/disability forms       |
| <input type="checkbox"/> History and physical             | <input type="checkbox"/> PPD             | <input type="checkbox"/> Prognosis             | <input type="checkbox"/> Copy of bill                |
| <input type="checkbox"/> Biopsychosocial                  | <input type="checkbox"/> Orders          | <input type="checkbox"/> Presence in treatment | <input type="checkbox"/> Family packet               |
| <input type="checkbox"/> Consults                         | <input type="checkbox"/> Diagnosis       | <input type="checkbox"/> Progress in treatment | <input type="checkbox"/> Other                       |
| <input type="checkbox"/> Medication administration record | <input type="checkbox"/> Progress notes  | <input type="checkbox"/> Nature of program     | <input type="checkbox"/> _____                       |

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

### Purpose of the disclosure is for/to:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Continuity of care                     | <input type="checkbox"/> Settle insurance claim        | <input type="checkbox"/> Discharge/Continuing care planning |
| <input type="checkbox"/> Keep family/Significant other involved | <input type="checkbox"/> Assist with legal issues      | <input type="checkbox"/> Keep employer/School involved      |
| <input type="checkbox"/> Fill out FMLA/Disability forms         | <input type="checkbox"/> Keep referral source involved | <input type="checkbox"/> Application for insurance          |
| <input type="checkbox"/> 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. 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).**

0The 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 (Check one)**