

**AUTHORIZATION FOR
RELEASE OF INFORMATION
MARWORTH
GEISINGER HEALTH SYSTEM¹**

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)

- | | | | |
|--|--|--|--|
| <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 & 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 | <input type="checkbox"/> Progress notes | <input type="checkbox"/> 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:

- | | |
|---|---|
| <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. 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).

¹Throughout 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.