

Montgomery Hospital Medical Center

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____
Patient Name Date of Birth

_____ hereby authorize Montgomery Hospital Medical Center to
Social Security Number
release the following information from my health records. The information that may be released is limited to: (check all that
apply)

_____ Discharge Summary _____ Operative Report _____ Abstract _____ Pathology Slides/
Blocks
_____ Laboratory Tests _____ Radiology Rpts/Films _____ Consults
_____ History & Physical _____ Pathology Reports _____ Progress Notes _____ Cardiac Studies/
Films

Other (please specify) _____

Pertaining to my admission(s) of: _____
(specify dates)

These records are required for the specific purpose of: _____

The information is to be released to:

Name, Title, Person or Organization

Address

City,

State

Zip

Telephone #

I understand that my authorization shall remain effective for a period of sixty (60) days from the date of my signature. I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time in writing to the Director of Health Information Management. I understand that any disclosure of information may be subject to re-disclosure by the recipient and no longer protected if the recipient is not covered by federal privacy regulations. I have also been informed of my right, subject to Section 5110.5 of the Mental Health Procedures Act, 1976 to inspect the information and Section 8 of the Pennsylvania Drug & Alcohol Abuse Control Act, 1972 and the Confidentiality of HIV-Related Information Act, 1991, which specifically limit disclosure.

Signature of Patient, Parent or Authorized Representative

Date

Signature of Witness

Date