POCONO HEALTH SYSTEM
206 East Brown Street, East Stroudsburg, Pa 18301
570-476-3388 Fax 570-476-3709

MEDICAL INFORMATION RELEASE

Encounter number: _____ **Medical Records Number:** _____

Patient Name	Social Security Number	Date of Birth
Patient Address		Phone Number

I authorize Pocono Health System to release my Medical Records to: _____

Name of doctor/hospital/insurance company /other agency
Attention
Address and/or Fax #
For the purpose of

Information from within the Hospital records relating to my identity, diagnosis prognosis or treatment.

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below as exception.
I also understand that my record may contain:

- AIDS/HIV-related information, if AIDS/HIV-related tests were ordered by my physician; Confidentiality of HIV-Related Information Act PA Law Act 148.
- Mental Health information, if mental health treatment was given by my physician; PA Mental Health Procedure Act
- Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician, Drug & Alcohol Abuse Control Act 42 CFR Part 2

Date(s) of Service _____

The information to be released is:

- ❑ Anesthesia Records
- ❑ Consultation Report
- ❑ d/c Planning
- ❑ Discharge Summary
- ❑ EKG, EEG, Stress, ECHO
- ❑ Emergency Dept Records
- ❑ Face Sheet/Demographic Sheet
- ❑ Films
- ❑ History & Physical
- ❑ Laboratory Results
- ❑ Onsite Review
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Psychiatric Evaluation
- ❑ Radiology
- ❑ Trauma Records
- ❑ Vascular Studies
- ❑ Verbal Information
- ❑ Other (Please specify)

_____
_____
_____
_____

❑ **EXCEPTION: I do not give permission to release (please specify):** _____
_____

I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that my protected health information may be disclosed by the provider for patient care purposes.

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given unless revoked by me.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected.

I understand that my authorization will remain effective for a period of 180 days from date of my request.

_____ _____
Patient's Signature/Date Witness to Signature/Date

_____ _____
Signature of Authorized Person/Date Witness to Signature/Date
Relationship: _____

❑ Unable to sign because: _____

PATIENT ❑ Received ❑ Refused a copy of this form
Information released to: _____ Date: _____

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FORMS 09/14