Temple University
Employee Health Services

✳Required fields

Temple University Employee Health Services
Request to Release Medical Information

✳Patient Name	✳Date of Birth	✳TUid Number:

✳Patient Address (Street, Apartment number, City, State, Zip)		
✳Telephone	Fax	Email address

✳Purpose of Release: ☐ Transfer records to another provider ☐ Legal Review ☐ School ☐ My own use ☐ Second opinion/consultation

I authorize the following provider/organization to disclose information from my health record as stated below: ☐ *Release to patient*

✳Information to be released *FROM*:

✳Name		
✳Street Address	✳Office/Ste#	
✳City, State, Zip		
✳Telephone	✳Fax	Email

✳Information to be released *TO*:

✳Name		
✳Street Address	✳Office/Ste#	
✳City, State, Zip		
✳Telephone	✳Fax	Email

✳Information to Be Released (Check all that apply)

☐ Consultations	☐ Immunizations	☐ Lab/Pathology/Other Study Reports	☐ Cardiac Testing ☐ EKG/EEGs
☐ Discharge Summary	☐ Radiology Reports	☐ Physical/Occupational Therapy Reports	☐ History and Physical
☐ Medication lists	☐ Operative Reports	☐ Office notes (except psychotherapy notes)	☐ Abstract

☐ Records for only these dates of service: From: To: ☐ All Records ☐ Other

Sensitive Records-I understand that my records are protected under the Federal Privacy Act, P.L. 93-75, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act 1976, and the Pennsylvania Confidentiality of HIV-Related Information Act and therefore cannot be disclosed without my written consent unless otherwise described in the regulations. I understand that my consent automatically expires as noted below.

AIDS/HIV Treatment	☐ Yes, release the records ☐ No, do not release the records.
Psychiatric Treatment	☐ Yes, release the information. My authorization expires thirty (30) calendar days from the date of my signature. ☐ No, do not release the information.
Alcohol/Drug Use Treatment	☐ Yes, release the information—My authorization expires ninety (90) calendar days from the date of my signature. ☐ No, do not release the information
Genetic Testing	☐ Yes, release the records ☐ No, do not release the records.
Sexually Transmitted Diseases	☐ Yes, release the records ☐ No, do not release the records.

This authorization expires one (1) year from the date of my signature unless an earlier date is requested or otherwise noted here:

Right to Cancel this Authorization: I understand that I have the right to cancel this authorization in writing (except to the extent that TUP has acted in reliance upon this authorization). Written request to revoke this authorization must be submitted to the Privacy and Security Officer at: Temple University Physicians, Privacy and Security Officer—Compliance Department, 3223 N. Broad Street, Room 412, Philadelphia, PA 19140. Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit disclosure. Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above whom I am authorizing to use and /or disclose my information may not base my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization. Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form. Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

✳Patient's or Legal Guardian's Signature	✳Date	Time ☐ a.m. ☐ p.m.

If not the patient, print the name of the person signing this form:	Authority to sign on behalf of the patient:☐ Parent ☐ Legal guardian Other_____ Proof of authorization and identification is required.

Temple University
Employee Health Services

✳Required fields

Temple University Employee Health Services
Request to Release Medical Information

✳Patient Name	✳Date of Birth	✳TUid Number:

Complete page two (2) only for verbal consent by a patient unable to sign, and when language interpretation is required.

☐ This is a verbal consent given by a person physically unable to sign.

Print the name of first witness: Signature:	Date	Time: ☐ a.m. ☐ p.m.

Print the name of second witness: Signature:	Date	Time: ☐ a.m. ☐ p.m.

Interpreter's Statement	
I have interpreted: ☐ the information explained to the patient by the healthcare provider accepting this release, and answered the patient's questions. I have done this using: ☐ American Sign Language or ☐ by speaking in the _____ language. To the best of my knowledge, he/she understood this interpretation.	
Interpreter's Name:	Record #: