

DEACONESS AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section 1

Patient Information (please print):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

- I hereby request IRON MOUNTAIN, on behalf of DEACONESS HOSPITAL, to release my medical records to MYSELF at the above address or to the address provided below in Section 3.
I have been a patient of DEACONESS HOSPITAL, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent.
I fully understand that the contents of my medical records may contain information relating to my identity, diagnosis, prognosis and/or treatment.

Section 2

Dates of Treatment: \_\_\_\_\_

Types of records to be released: [ ] Medical Records [ ] Radiology Films [ ] other: \_\_\_\_\_

Information to be released:

[ ] Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's OR Reports, Discharge Summary, ER Report)

\*This is the information typically needed by a new physician for continuing care\*

[ ] Discharge Summary [ ] Operative Reports [ ] Consultation [ ] H&P [ ] Progress Notes [ ] Radiology Reports

[ ] Lab Results [ ] Emergency Department [ ] Outpatient/Clinic (specify): \_\_\_\_\_

[ ] The above information including any HIV-Related Information.

[ ] The above information including any mental health, drug or alcohol treatment information.

[ ] Other (specify): \_\_\_\_\_

Purpose of obtaining records: [ ] Continuing Medical Treatment [ ] Employer [ ] Insurance [ ] Legal

[ ] Study/Research [ ] Other: \_\_\_\_\_

[ ] I do not wish to disclose the reason

Section 3

Mail Records To: \_\_\_\_\_

Section 4

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION WILL BE CONSIDERED VALID UNLESS OTHERWISE SPECIFIED. I UNDERSTAND THAT RECIPIENTS MAY REDISCLOSE INFORMATION, WHICH I HAVE AUTHORIZED THEM TO RECEIVE. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED.

I ALSO UNDERSTAND THAT THE ORIGINAL FILMS WILL BE RELEASED AND THAT NO BACK UP COPIES WILL BE AVAILABLE. ONCE THESE FILMS ARE RELEASED, I WILL BE SOLELY RESPONSIBLE FOR THEIR DISPOSITION. I RELEASE DEACONESS HOSPITAL OF ALL LIABILITY WITH REGARD TO STORAGE OF THESE FILMS.

I HEARBY STATE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF REORDS FOR THE PURPOSE (S) STATED ABOVE.

Patient or Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

If patient is unable to sign please state reason: \_\_\_\_\_

(Legal Representative signature may require attaching supporting legal documentation to include; Death Certificate, Power of Attorney, Executor of Estate papers to support your claim as to being the legal representative.

Medical Records Fees\*

Search and Retrieval Fee \$15.00

Per page 1-10 \$1.00

Per page 11-50 \$0.50

Per page 51 and over \$0.20

Actual Postage

Radiology Fee

\$25.00 Flat Fee

\*All fees are subject to State Legislated Rates and may be subject to change.

Mail Completed Request to:

Iron Mountain

Attn: Correspondence

1600 West Carson Street

Pittsburgh, PA 15219