Hershey ALS Clinic
Steps to Release Medical Records

When multiple medical records are needed through the ALS Clinic, we ask that you initiate the following process to obtain records through the Medical Records Department. The Clinic team will continue to complete and obtain needed signatures for the disability and insurance claims, but the multiple records that support these requests will need to be processed according to the following steps:

1. Determine who needs the medical records and obtain their contact information.
   -if you provide the contact information for a company, you will not receive any verification that the task has been processed unless you want to call the Medical Records Department yourself. Please expect it to take 14 days to fulfill your request.
   -if you fill out the form so that you are receiving the records, you will be aware of the task being completed, but then will need to forward the information to the company yourself.

2. Carefully fill out the Medical Release form attached, being sure to list who the information should go to along with their address and what exact information you would like included. Be sure that the Release is completely filled out or the request will not be honored.

3. Send your request and signed Authorization for Release of Medical Records form to:

   Penn State Hershey Medical Center
   500 University Drive
   P.O. Box 850
   Attn: HIS/Healthport HU24
   Hershey, PA 17033

4. If you would like to follow-up with confirming the information has been sent, you may call 717-531-1635. Please allow two weeks for the records to be processed.

There may be a charge assessed by HMC for the processing of any Medical Records request.

PennState Health

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Penn State Health, Health Information Management, Mail Code HU24, P.O. Box 850, Hershey, PA 17033-0850 • Phone: 717-531-8055 • Fax: 717-531-5068

I. PATIENT INFORMATION:

Name: ____________________

Date of Birth: ____________________ Medical Record Number: ____________________

Phone: (____)____________________ Patient Email address*: ____________________

THE INFORMATION BEING DISCLOSED MAY INCLUDE: HIV/AIDS, DRUG/ALCOHOL TREATMENT & MENTAL HEALTH DATA.

REASON FOR REQUEST - please complete addressee field below in all cases:

☐ For patient's own use, including continuing care

☐ For Penn State Health to send medical information or images to another entity

☐ For requesting this patient's medical information or images to be sent from another facility to Penn State Health

☐ For a Penn State Health employee/agent to speak to another person or entity in person, by phone, or other communication media

I HEREBY AUTHORIZE ____________________
(Name of Authorized Employee or Agent of Penn State Health)

TO DISCUSS MY HEALTHCARE INFORMATION (CHECK OPTION BELOW) WITH THE AUTHORIZED PERSON, AGENCY, INSTITUTION OR OTHER NOTED IN SECTION II.

☐ All medical information known by employee/agent about me.

☐ All medical information known by employee/agent related to treatment provided to me at Penn State Health.

☐ Other (Please specify): ____________________

☐ Other: ____________________

Please note there may be costs associated with requests for additional documents beyond what is provided in suggested Abstracts 1-3 *(see attached letter)*

Specific reason for request: ____________________

WHERE DID YOU RECEIVE HEALTHCARE? PLEASE CHECK ALL THAT APPLY.

Penn State Health:

☐ Hershey Medical Center ____________________ ☐ St Joseph Medical Center ____________________

☐ Holy Spirit Medical Center ____________________ ☐ Hampden Medical Center ☐ Lancaster Medical Center

☐ Clinic location ____________________

II. ADDRESSEE FIELD:

☐ **RECEIVE INFORMATION FROM:**	☐ **RELEASE INFORMATION TO:**
(Name of Patient, Authorized Person, Agency, Institution or other)	*(Name of Patient, Authorized Person, Agency, Institution or other)*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*

III. FORMAT IN WHICH YOU WOULD LIKE TO RELEASE OR RECEIVE MEDICAL INFORMATION:

☐ Medical Record on Paper ☐ Medical Record on CD

☐ Radiology Images on CD ☐ Medical Records via Internet *

☐ Penn State Hershey Medical Center Patient Portal
** This option only available for records going directly to patient or parent of minor/POA/legal guardian*

IV. MEDICAL INFORMATION OR IMAGES BEING REQUESTED:

Please provide the type(s) of medical records information requested by checking the boxes and listing their dates of service below:

(List dates of service here) ____________________

PennState Health

MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

☐ **Abstract 1: INPATIENT Medical Records (Up to 2 years old):**
Provides Consult, Diagnostic Test Results, Emergency Department & Discharge Summaries, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Lab reports

☐ **Abstract 2: OUTPATIENT Medical Records (Up to 2 years old):**
Provides Consult, Diagnostic Test Results, Emergency Department, History and Physical, Medication Allergies, Medication List, Problem List, Procedures, Pathology Report, Outpatient Letter, Outpatient Clinic Notes, Lab reports.

☐ **Abstract 3: Only Diagnostic Test Result(s) (Up to 2 years old):**
For example, Radiology, EEG, EKG, Cardiology Studies, Pathology, Pulmonary Studies
(specify Type of Test & Date) ______________________________

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☐ **Other:**
- ☐ Discharge Summary(ies) Reports
- ☐ History & Physical Reports
- ☐ Laboratory Results
- ☐ Serial #/Product ID # for implanted devices
- ☐ Outpatient Letters/Notes Reports
- ☐ Daily Progress Notes Reports
- ☐ Operative Report, Procedure Reports
- ☐ Radiology Image(s) – specify type and date
- ☐ Other **(please specify what document and date of services)** ______________________________

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Please contact us with any questions or concerns at 717-531-8055

V. PATIENT OR REPRESENTATIVE SIGNATURE:

This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form, to the attention of the Director, Health Information Management. If not previously revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at Penn State Health. Neither our treatment nor your payment is conditioned upon your signature on this form.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

______________________________ ______________________________
Signature of Patient or Representative *Date/Time*

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Relationship if signed by other than Patient

ORAL AUTHORIZATION (for persons unable to sign)

NOT Applicable to HIV-related Information or Drug & Alcohol Treatment Information

I witness that the patient/parent/legal guardian understood the nature of this release and freely gave their oral authorization (Two Witnesses are required)

______________ ______________ ______________ ______________
Witness # 1 *Date/Time* *Witness # 2* *Date/Time*

______________________________ ______________________________
Information Released by *Date/Time*

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.

This document authorizes release of information entered into my medical record prior to or within 12 months after the date of my signature

PLEASE RETURN THIS FORM IMMEDIATELY TO HEALTH INFORMATION MANAGEMENT @ 717-531-5068

Note to recipient of information: This information has been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits 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.