

Physicians' Alliance, Ltd.
General Internal Medicine of Lancaster

2301 Columbia Avenue, Lancaster, PA 17603
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*A growing alliance of healthcare providers dedicated to
the welfare of their patients.*

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AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to release the records:

_____ General Internal Medicine of Lancaster _____
Name of Facility

_____ 2301 Columbia Ave., Lancaster, PA 17603 _____
Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

Complete Medical Record

Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

History & Physical (H&P)

X-ray and imaging reports

Discharge Summary

Progress Notes

Operative Report

Laboratory Test Results

Consultation Reports

Immunization Record

Other- list specific Items: _____

Behavioral Health Reports:

Social History

Treatment Plan

Client Data Form

Academic History

Referral/Treatment Form

Aftercare Instructions

Admission Evaluation

Psychological Evaluation

Notification of Admission

Other – list specific items: _____

3. I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. **This information may be released to and used by the following individual/organization:**

Name: _____

Address: _____

For the purpose of:

- Further Medical Care
- Legal Investigation or Action
- Changing Physicians
- Insurance Eligibility/Benefits
- Personal
- Other (please specify): _____
- Inspection/Copying of my records

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #7 above.

8. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

9. I understand that if this chart request is for a transfer of care, there will no charge for the first copy of records. These records will include our standard copies which include the last three years of treatment. However, any additional copies of the standard record will be subject to a prepayment of \$25.00 each. If your request is for your complete chart, which may exceed our standard copy, you may be charged a per page fee which has been established in the state of Pennsylvania – Act 26 of 1998. If this situation does occur, the Medical Records Department of GIM will notify me of these impending charges and these records will be paid in full before release by GIM.

10. I understand that there may be a fee for records requested from other physicians and that it may be my responsibility to pay for these. In some cases, these physicians may not release records to General Internal Medicine until payment has been made.

Signature of Patient

Date

Name of Patient (Please Print)

- Patient is: Minor Incompetent Disabled Deceased
- Legal Authority: Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Health Care Authorized Legal Personal Representative

I, _____, represent that I am the representative for the patient as checked above.

Representative's Signature: _____

Address: _____ Phone: _____

If you are the healthcare agent or guardian, please attach proof of your authority to act on behalf of the patient. In the case of incompetence, acceptable proof is copy of the medical power of attorney. If patient is deceased, an executrix agreement, or short certificate, must be provided. If there is no executor, then the next-of-kin will act on behalf of the deceased.

Signature of Witness

Date