GVH
GRAND VIEW HOSPITAL

P.O. Box 902
700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4000

PATIENT AUTHORIZATION

I hereby authorize ______________________________
Name of Facility and Address

to disclose the following information from the health records of:

Patient Name ______________________________ Date of Birth ______________

Address ______________________________ City ______________ State ______ Zip Code ________

Email address ______________________________ Telephone No. ______________________

Date(s) of service ______________________

Information to be disclosed: * Included in Abstract

- ☐ Abstract*
- ☐ Consultation Report*
- ☐ Discharge Summary*
- ☐ EKG, EEG, Stress, ECHO*
- ☐ Emergency Dept Records
- ☐ History & Physical*
- ☐ Immunizations
- ☐ Laboratory Results*
- ☐ Operative Report*
- ☐ Pathology Reports*
- ☐ Progress Notes
- ☐ X-ray Film
- ☐ X-ray Report*
- ☐ Other (please specify) ______________________
- ☐ Physician's Office Records (available only at the physician's office)

I understand that this will include information relating to (check if applicable);

- ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- ☐ Behavioral Health services / psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

☐ **Exception: I do not give permission to release (please specify):** ______________________

This information is to be disclosed to:

____
Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self

Address: ______________________________ Fax #: ______________________
(Healthcare organization only)

____

For the Purpose of:

- ☐ Continuation of Care
- ☐ Social Security/Disability
- ☐ Insurance Purposes
- ☐ Legal Purposes
- ☐ Personal Access
- ☐ Other: ______________________

- Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.
- I understand that Grand View Hospital may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I also understand that this consent may be revoked by me at any time by submitting a written revocation notice.
- I understand that if this form is submitted electronically to GVH, there is no guarantee of secure transmission until it is received by GVH.

I understand that my authorization will remain effective until the end of the calendar year.

Patient's Signature ______________________________ Date ____________

The above individual is unable to consent/sign because (check one):

☐ Minor If minor, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
If yes, Legal documentation provided? ☐ Yes ☐ No

☐ Incompetent

☐ Other (explain): ______________________________

______________________________ ____________ ______________
Authorized Representative Signature Date Relationship

For office use only:

ID Confirmed: ☐ Yes ☐ No

MRN# ____________ Encounter # ____________ Released By: ______________________

- ☐ Patient Identification
- ☐ Photo ID
- ☐ POA Provided

Given to: ______________________ Date & Time ______________________