Label Area

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

I HEREBY AUTHORIZE:
Name of Person or Institution:

Address:	City/State/Zip
Telephone Number:	Fax Number:

To Disclose the following Information (check all items to be released)

☐ Discharge Summary	☐ Operative Report	☐ Lab Reports	☐ Radiology Images
☐ Discharge Instructions	☐ ER Record	☐ EKG/ECG Tests	☐ Medication Records
☐ History and Physical	☐ X-Ray Reports	☐ Progress Notes	☐ Physician Orders
☐ Consultations			

☐ Other Instructions: _____

Covering the period (s) of care (list applicable dates of treatment):_____

Special Records:

I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below:

AIDS.HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
☐ Yes, disclose	☐ Yes, disclose	☐ Yes, disclose
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

To the following Penn Medicine entity/physician:

Shyama Mathews, MD
Penn Medicine Princeton Physicians
5 Plainsboro Road, Suite 450
Plainsboro, NJ 08536

Phone: (609) 853 6555
Fax: (609) 683 6950

Purpose /Use of the Requested Information is Continuity of Care

Authorization

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.
I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing.
I understand the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient or Personal Representative | Print Name | Date | Time

Relationship of Personal Representative to Patient | Date | Time

If Authorization is signed by someone other than the patient, please state reason: _____