Doylestown Hospital
595 West State Street Doylestown, PA 18901

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Last 4 Digits of SS #: _____ MR #: _____

Release Records to: _____

_____

Dates of Information to be released: _____

☐ Entire Record	☐ ECG/Cardiology Testing Results	☐ Medication List
☐ Consults	☐ ER Record	☐ Progress Notes
☐ Discharge Summary	☐ H&P	☐ Radiology Results
☐ Discharge Instructions	☐ Lab Results	

Other: _____

These Records are needed: ☐ **For personal use** ☐ **For continuation of care**

I understand my rights as a patient include the following:

a. My records may contain sensitive or extremely private information including, but not limited to, a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, surgeries, and any other medical or psychological disorder for which I may have been treated.
b. I, or my representative, can revoke or modify this authorization at any time by writing to HIS of Doylestown Hospital for any future disclosures. This will not affect any disclosed information previously authorized.
c. The hospital will not make decisions about treatment, payment, enrollment or eligibility based on this authorization.
d. Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
e. I cannot be compelled to authorize release of any of my medical records.

☐ This authorization expires on: _____ ☐ This authorization has no expiration date

_____ _____
Patient signature Date

If person signing is someone other than patient:

_____ _____
Signature Date

_____
Print Name

_____
Relationship to patient and authority to sign (i.e. legal guardian, Power of Attorney)

THIS FORM IS TO BE KEPT AS A PART OF THE PATIENT PERMANENT RECORD

Photo ID type and #: _____ Hospital Assoc. Signature: _____

Reviewed: 1/15, 6/17, 3/18
Revised: 8/11, 9/11, 10/13, 6/15, 9/20, 2/24