SALEM Township HOSPITAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Revised: January 28, 2015

PATIENT NAME: (print clearly) _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

I hereby authorize Salem Township Hospital, including Medical Office Practices and/or Rural Health Clinics owned and operated by Salem Township Hospital to disclose protected health information, as specified below, to the following:

Facility or Office:	
Address:	
City, State, Zip Code:	
Telephone Number:	

I hereby authorize Salem Township Hospital, including Medical Office Practices and/or Rural Health Clinics owned and operated by Salem Township Hospital to obtain protected health information, as specified below, from the following:

Facility or Office:	
Address:	
City, State, Zip Code:	
Telephone Number:	

Please check (☑) the specific information to be released:

- ☐ Face Sheet/Registration Form
- ☐ Emergency Room Record
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Entire Medical Record
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Other Test Reports
- ☐ Other: _____

Date of Treatment/Services: _____

Type of Encounter: ☐ Medical/Surgical ☐ Mental Health ☐ Drug/Alcohol ☐ AIDS/HIV Test

Purpose of Disclosure: ☐ Continuing Medical Care ☐ Insurance Claim ☐ Legal Counsel

☐ Other: _____

I fully understand that my medical record and/or information in connection with the hospitalization/treatment date(s) stated above may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results and/or information. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only by my authorization, unless otherwise required or permitted by law. Only such records and/or information believed necessary for the purpose expressed above shall be disclosed. I may inspect and arrange for photocopies of the records/information that are to be disclosed at my own cost and per hospital policy. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Health Information Department of Salem Township Hospital. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule. I agree to release and hold harmless Salem Township Hospital, its directors, officers, employees, successors, agents, assigns, and any and all members of its medical staff from and against any and all liability, damages, claims, or suits, including reasonable attorneys fees, in connection with the disclosure of records/information as authorized herein. Salem Township Hospital may not condition treatment, payment, enrollment, or eligibility for benefits on whether an individual signs this authorization.

SALEM Township HOSPITAL

This authorization will expire in 90 days from date of signature below unless revoked by patient or legal guardian prior to 90 days.

Signature of Patient	Date
Signature of Legal Guardian/ Durable Power of Attorney for Healthcare	Date
Witness	Date

If requested, a copy of this authorization may be provided to the patient and/or legal guardian or durable power of attorney for health care upon completion.

FEES FOR MEDICAL RECORD COPIES

(As mandated by law, P.A. 92-0228: Effective 09-01-2001; revised under P.A. 95-478 and 95-480: Effective January 28, 2015)

PROCESSING FEE: $26.58 (This includes the first five (5) pages)

(Processing fee does NOT apply to the patient or those involved in the patient's healthcare decisions)

PAGES 01 THRU 25:	$ 1.00 Per Page
PAGES 26 THRU 50:	$ 0.66 Per Page
PAGES 51 AND MORE:	$ 0.33 Per Page
RECORDS RETRIEVED FROM MICROFILM:	$ 1.66 Per Page
RECORDS RETRIEVED FROM SCANNING/DIGITAL	(Same as paper fee/rate)
RECORDS RELEASED IN ELECTRONIC FORMAT	50% of paper rate for the number of pages
WORKERS' COMPENSATION RECORDS:	$20.00 Witness Fee (Flat Fee)
POSTAGE & SHIPPING	(Actual Cost of Postage & Shipping)

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INVOICE

(For Office Use Only)

	Number of pages	Charge per page	Total
Processing Fee @ $26.58		$26.58	
Number of pages @ $1.00		$1.00	
Number of pages @ $0.66		$0.66	
Number of pages @ $0.33		$0.33	
Number of pages from microfilm @ $1.66		$1.66	
Number of pages retrieved from scanning/digital (Fees same as paper rate)			
Number of pages released in electronic format (50% of cost of paper rate)			
Total charges			