

## Authorization for Use or Disclosure of Protected Health Information Form

Patient Name			Date of Birth
Full Address: Street/City/State/Zip			
Phone Number	Email Address	Medical Record # (if known)	Social Security Number (last 4 digits only): _____
<b>Disclosed Information (check all items to be released)</b> <input type="checkbox"/> Laboratory/Pathology Reports and Records <input type="checkbox"/> Billing <input type="checkbox"/> Other (please specify): _____ OPTIONAL LIMITS <input type="checkbox"/> Only the information related to: (e.g., testnames) _____ <input type="checkbox"/> Covering the period(s) of care (date range or specific date of service): _____		<b>Purpose/Use of the Requested Information</b> <input type="checkbox"/> At the request of the patient or personal representative <input type="checkbox"/> Continued care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other (please describe): _____ _____ <p style="text-align: center; color: red;"><b>Please complete all bolded fields.</b></p>	
I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, sexually transmitted diseases, psychiatric care and treatment, treatment for drug and alcohol abuse, unless I check the appropriate box(es) below.			
HIV/AIDS Information <input type="checkbox"/> No, do not disclose	Sexually Transmitted Diseases <input type="checkbox"/> No, do not disclose	Psychiatric Care/Treatment <input type="checkbox"/> No, do not disclose	Treatment for Drug or Alcohol Use/Abuse <input type="checkbox"/> No, do not disclose
<b>Information Provided To</b>			
Name of Person or Institution	Relationship to the Patient <input type="checkbox"/> Self <input type="checkbox"/> Parent or Personal Representative <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		Phone Number
Full Address: Street/City/State/Zip			Date Needed By*
<b>Method of Delivery of Results</b> <input type="checkbox"/> US Mail <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Fax # _____ <input type="checkbox"/> Other (please specify): _____			
<b>Authorization Expires (check appropriate box)</b> <input type="checkbox"/> One year from date of authorization <input type="checkbox"/> Other date (please specify): _____ (May not be more than one year from signature date) <b>If no expiration date is designated, this authorization will expire one year from the signature date.</b>			
<b>Authorization</b> I authorize Health Network Laboratories, L.P. d/b/a Health Network Laboratories, HNL Lab Medicine and Connective Tissue Gene Tests, (collectively "HNL") to use or disclose the health information described above. I understand the following: 1) HNL will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether or not I provide authorization for the requested use or disclosure; 2) I may revoke this authorization at any time, including in advance of the expiration date; 3) I have the right to revoke this authorization in writing at any time by sending such written notification to the <b>HNL Privacy Officer at 794 Roble Road, Allentown, PA 18109-9110</b> ; 4) my revocation will not be effective to the extent that HNL has already acted in reliance on this authorization; 5) I have the right to refuse to sign this authorization; 6) I have the right to inspect or copy the protected health information to be used or disclosed as permitted under Federal law (or state law to the extent the state law provides greater access rights). HNL cannot prevent re-release of the information by the person or institution who receives such information and federal and state law may no longer protect it. I release HNL and its staff from any and all liability resulting from such re-release. I have read and understand this form, and authorize use and release of the information as described above.			
X _____ Signature of Patient or Personal Representative		_____ Date	
<b>Print Name</b>		<b>Relationship of Personal Representative to Patient</b>	
If Authorization is signed by someone other than the patient, please state the reason.			
Records of deceased patients: If the requestor is not the executor of the deceased patient's estate then the requester certifies by signing above that he/she is the next of kin responsible for the disposition of the deceased patient's remains.			
<b>Verbal Release of Patient Health Information:</b> If the patient is deemed competent, but physically unable to sign for himself/herself, such as in the case of a physically disabled person, a verbal consent will be accepted from the patient provided it is witnessed by two parties. We, the undersigned, certify that the patient identified above was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.			
X _____ Signature of Witness #1	_____ Title	_____ Date	Internal Use Only Receipt Confirmed: By: _____ Date: _____ Complete Date: _____ Records Sent: By: _____ Date: _____
X _____ Signature of Witness #2	_____ Title	_____ Date	

## Instructions

1. Please complete all bolded sections of the authorization.
2. The patient or legally authorized representative must sign and date the form. Generally, only a patient may authorize release of his/her medical information. Notable exceptions to the rule are as follows:
  - a. Authorization of Minors: If the patient is a minor (under 18 years of age) the authorization must be signed by a parent or legal guardian. At the discretion of HNL, two signatures may be required to release a minor's records.
  - b. Mental Health Records: Minors 14 years of age and older may consent to mental health treatment and, therefore, may also authorize release of their mental health treatment records.
  - c. Regulatory Authority: Minors who are married, have been pregnant, or are high school graduates may consent to their own treatment and, therefore, may also authorize release of the medical records for that treatment. Minors may also consent to treatment and authorize record release for their own children.
  - d. Emancipated Minors: An emancipated minor is a minor who has left the parental household, supports him/herself financially, and lives independently. Emancipated minors can consent to their own treatment and therefore may also authorize release of their medical information.
  - e. Minors and Highly Confidential Information: Minors who have been diagnosed with a venereal disease, a substance abuse problem or were treated to determine pregnancy may consent to treatment for that disease or condition and, therefore, may authorize release of any medical information related to that treatment.
  - f. Authorization after Death: An authorization must be signed by the executor of the decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
  - g. Authorization of the Legally Incompetent Patient: If the patient is deemed legally incompetent, then the patient's legally authorized representative (e.g., guardian or agent under a power of attorney) may sign the authorization for release of information. HNL reserves the right to request proof of identity and representation.
3. Please mail the completed form to:

**Health Network Laboratories, L.P.**  
**Customer Care Department**  
**794 Roble Road**  
**Allentown, PA 18109-9110**

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### PLEASE NOTE

HNL may charge for records in accordance with Pennsylvania Department of Health Notice regulated by Act 26 (51 Pa.B. 7570) and the Health Insurance Portability and Accountability Act (45 CFR Parts 160-164). Copying fees are updated January 1<sup>st</sup> of each year.

#### 2022 PA Patient Fees

Amount charged per page for pages 1-20	\$1.70
Amount charged per page for pages 21-60	\$1.26
Amount charged per page for pages 61-end	\$0.44
Flat fee for production of records to support any claim under Social Security or any Federal or State financial needs-based program . . .	\$31.94
Flat fee for supplying records requested by a district attorney	\$25.20
Search and retrieval of records	\$25.20

*Flat fees apply to amounts that may be charged by a health care facility or health care provider when copying medical charts or records either: (a) for the purpose of supporting any claim or appeal under the Social Security Act or any Federal or State financial needs based program; or (b) for a district attorney.*

In addition to the amounts listed previously, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records.

- HNL will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information not maintained on site. If HNL is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
- HNL may deny this request under limited circumstances as provided for under state or federal law. HNL will notify you if it denies your request to access or obtain a copy of the requested information. If HNL denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.