# 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): __ __ __ __** |
|---|---|---|---|

**Disclosed Information *(check all items to be released)***

□ Laboratory/Pathology Reports and Records
□ Billing
□ Other (please specify):_____

OPTIONAL LIMITS
□ Only the information related to: (e.g., test names)
_____
□ Covering the period(s) of care (date range or specific date of service):
_____

**Purpose/Use of the Requested Information**

□ At the request of the patient or personal representative
□ Continued care
□ Insurance
□ Legal
□ Other (please describe):_____
_____

***Please complete all bolded fields.***

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 | Sexually Transmitted Diseases | Psychiatric Care/Treatment | Treatment for Drug or Alcohol Use/Abuse |
|---|---|---|---|
| □ No, do not disclose | □ No, do not disclose | □ No, do not disclose | □ No, do not disclose |

**Information Provided To**

| **Name of Person or Institution** | **Relationship to the Patient**<br>□ Self □ Parent or Personal Representative □ Health Care Provider<br>□ Spouse □ Child □ Other:_____ | **Phone Number** |
|---|---|---|
| **Full Address: Street/City/State/Zip** | | Date Needed By* |

**Method of Delivery of Results**

□ US Mail □ Encrypted Email □ Fax # _____ □ Other (please specify):_____

**Authorization Expires (check appropriate box)**

☐ One year from date of authorization
☐ Other date (please specify):_____(May not be more than one year from signature date)

**If no expiration date is designated, this authorization will expire one year from the signature date.**

**Authorization**

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 **HNL Privacy Officer at 794 Roble Road, Allentown, PA 18109-9110**; 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**

_____
**Print Name** **Relationship of Personal Representative to Patient**

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.

Verbal Release of Patient Health Information: 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

X_____ _____ _____
Signature of Witness #2 Title Date

*Internal Use Only*
Receipt Confirmed:
By:_____Date:_____
Complete Date:_____
Records Sent:
By:_____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 identify 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 1st of each year.

2023 PA Patient Fees

| *Amount charged per page for:* | *Not to Exceed* |
|---|---|
| Pages 1 – 20 | $1.83 |
| Pages 21 – 60 | $1.36 |
| Pages 61 – end | $0.47 |
| Microfilm copies | $2.70 |
| * Search and retrieval of records (cannot be charged if requestor is requesting their *own* personal health record) | $27.14 |
| | |
| *Flat fees (providers may not charge the above search and retrieval fee in addition to a flat fee)* | |
| Production of records to support any claim under Social Security or any Federal or State financial needs-based program; | $34.40 |
| Supplying records requested by a district attorney | $27.14 |

Fees cab be found on the Department of Health website - https://www.health.pa.gov/topics/Administrative/Pages/Medical-Record-Fees.aspx

*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 you request reviewed by a licensed health care professional.