Health Information Management Department
267-295-1602

Date: _____

This authorizes: _____

Address: _____

_____

(Office Telephone Number) (Office Fax Number)

To release medical information to John F. Kennedy Medical Center on your patient

NAME: _____ DATE OF BIRTH: _____
(PRINT NAME CLEARLY)

ADDRESS: _____ SOCIAL SECURITY #: _____

_____ TELEPHONE #: _____

TREATMENT DATE: _____

PURPOSE OF DISCLOSURE: _____

INFORMATION REQUIRED: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to you to release to John F. Kennedy Medical Center such information as may be necessary from my medical record.

I understand that this authorization shall remain valid from the date of my signature and shall remain in effect for 60 days thereafter.

I understand that I may revoke this authorization (except to the extent that action has been taken). Medical Record information pertaining to Drug and Alcohol abuse is protected by Federal Confidentiality Laws. Re disclosure is prohibited.

I understand that the Medical Record may contain Psychiatric information or Drug and Alcohol Abuse HIV/AIDS diagnosis/treatment/testing Information.

I certify that I understand the contents of this consent form and its purpose.

_____ _____
Patient's Signature Date of Signature

_____ _____
Person Authorized in Lieu of Patient Relationship to Patient

_____ _____
Witness's Signature Date of Signature

PLEASE SEND PHOTOCOPIES TO THE ATTENTION OF THE MEDICAL RECORD DEPARTMENT
3001 WALNUT STREET.PHILADELPHIA, PENNSYLVANIA 19104. OR FAX (215-386-3101).

REVISED: 08/13 Medical Records Other Records