## Prospective Authorization to Release Electronic Health Information

TEMPLE HEALTH

**Patient Name** **Date of Birth** **Last Four Digits of Social Security Number:**

X X X—X X—☐☐☐☐

### 1. Consent for treatment

☐ I authorize the physicians and staff of Temple Health (including Temple University Physicians, Temple Physicians Inc., Temple University Health System, and Fox Chase Cancer Center Medical Group Inc.) to assess my health care conditions and to provide care, services, clinical imaging, or other therapies necessary to effectively diagnose and treat me.

☐I do not consent.

### 2. Authorization to Release Electronic Information

☐I authorize Temple Health to electronically release information from my health record for the sole purpose of medical care to other health care providers or organizations from which I may seek treatment and/or to which I am referred by Temple Health. This authorization is in effect unless revoked (see below).

### 3. No authorization to Release Electronic Information

☐ I do not authorize Temple Health to electronically release information from my health record to other organizations or health care providers. I understand that I have the right to change this authorization at any time by completing and submitting a new *Prospective Authorization to Release Electronic Health Information* form.

**Information to be released** may include physician progress notes, current and historical information about diagnosis, problem list, medications and drug allergies, immunizations, laboratory and procedure test results, vitals, smoking status, care plan, clinical imaging, and demographics. This release does not authorize the use of patient information for purposes other than treatment, payment for medical services, and clinical practice operations.

**Sensitive Information: I understand that if I have been treated for AIDS/HIV, drug or alcohol dependence, psychiatric and/or reproductive health issues, my records may contain information about that treatment.** I understand that my records are protected under the Federal Privacy Act, P.L. 93-75, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act 1976, and the Pennsylvania Confidentiality of HIV-Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise described in the regulations. **I understand that if I do not want these sensitive records shared, I should check the box under 3 (three) above "I do not authorize Temple Health to electronically release information from my health record with other organizations or health care providers", and sign below.**

**Right to Revoke this Authorization:** I understand that I have the right to revoke this authorization in writing (except to the extent that Temple Health has acted in reliance upon this authorization). To revoke this authorization I may complete a new *Prospective Authorization to Release Electronic Health Information* form and submit it to my provider's office, or send a written request to Temple University Physicians, Operations Center, Attention Privacy and Security Officer, Kresge Hall, 3440 N. Broad Street, Room 100, Philadelphia, PA 19140.

**4. Patient or Legal Guardian's Signature:** **Date**

✳ If someone other than the patient signs this authorization, **proof of authorization and identification is required.**

**If not the patient, print the name of the person signing this form:** **Authority to sign on behalf of the patient:**

☐ Parent ☐ Legal guardian ☐ Other _____

**5. ☐ This is a verbal consent given by a person physically unable to sign.**

Print the name of first witness:_____ **Date**

**Signature:**

Print the name of second witness:_____ **Date**

**Signature:**

**6. Interpreter's Statement:** I have interpreted ☐the information and advice explained to the patient by the healthcare provider getting this consent and ☐the patient's questions to the healthcare provider. I have done this using: ☐ American Sign Language or by speaking in _____ language. To the best of my knowledge, he/she understood this interpretation.

**Interpreter:** **Case/Record#:** **Date:**