

## Protected Health Information Authorization for Release, Use, and Disclosure

Mailing address: P.O. Box 16052, Reading, PA 19612

Located at: 420 South 5th Avenue, West Reading, PA 19611

Health Information Management - Telephone: 484-628-8252

Last Name	First Name		Date of Birth	MRN
Address		Phone	Email	
I authorize		to rel	ease my Medical Records to:	☐ Me or ☐ Recipient:
Name of Authorized Person, Doctor, Hospital, Agency or Other			Phone	
Address			Fax	
ATTENTION PATIENT: I understand and authorize the release of If included in the medical record, this auth related information or testing), Mental He permitted by law.	norization includes the release of ir	nformation protected by: Cor		
Information to be released:	Date(s) of Service:			
<ul> <li>Discharge Summary</li> <li>Emergency/Trauma Records</li> <li>Labs</li> <li>Abstract of Medical records = H&amp;P, Disc</li> <li>Electronic Abstract = Discharge Summa</li> <li>Other =</li></ul>		esults, Problem List, Medicatio	ges □ Re ough MyTowerHealth) □ Sp ons, Allergies and Procedure re	•
	Complete Medi	ical Record D Billing Reco	ord	
Reason for Disclosure: D Person	al 🗍 Further Medical Care 🗌	Legal Investigation or Actio	n 🛛 Other:	
Out of Reading Hospital to:				
I would like to receive this information VI/	A:		nt Portal 🛛 Other:	
I understand the following: I may revoke to this authorization. The information dis the terms of this authorization. I have the authorization and that my refusal to sign compensation for medical record copying upon my death, whichever occurs earlier.	closed in response to this authoriza right to inspect or copy the health will not affect my ability to obtain t	ation may be subject to re-dis n information to be used or di treatment, or my eligibility for	closure by recipient, and will a sclosed as permitted by law. benefits (if applicable). Read	no longer be protected under I may refuse to sign this ling Hospital may receive
Signature of Patient or Authorized Repre	esentative Date	Signature of Witness		Date
Printed Name of Patient		Printed Name of Wit	ness	
Relationship to Patient		Title/Department		

# **Important Information about Medical Records Requests**

#### **Requesting Your Records**

The Records Release Center of our Health Information Management Department is available to assist you with obtaining copies of your medical records and radiology images. You may contact us by:

Telephone: 484-628-8252 Fax: 484-628-9777 Mail: Reading Hospital Records Center, PO Box 16052, Reading, PA 19612-6052

#### **Picking Up Your Records**

We highly recommend calling at least 24 hours in advance so that your records will be ready when you arrive. Records can then be picked up in our: **Records Release Center** 

Located at: 420 South 5th Avenue, West Reading, PA 19611 5th Avenue lobby of the Reading Hospital Open Weekdays, 8 a.m. to 7 p.m.

#### To Access the Records Release Center

Use the 5<sup>th</sup> Avenue entrance to our West Reading Campus

Park in the patient drop-off spaces near the revolving door or use the free valet service for parking.

Enter through the revolving door.

Records Release Center is located to the left of the main Reception Desk in the lobby.

#### Identification Required.

Please bring a driver's license or other photo identification card. If you are picking up records for an adult 18 years of age and older, you must also have either: a note signed by the patient authorizing you to pick up his/her records OR Medical Power of Attorney documentation OR Legal Guardianship documentation.

#### **Receiving Records Through MyTowerHealth Patient Portal**

Receive in 3-5 days. Records will be available to access and download for 14 days. Medical Records from 2/2/13 to present can be provided through the MyTowerHealth Patient Portal. Radiology images are not available through MyTowerHealth Patient Portal

### **Other Services**

To review your medical records, please call us for an appointment at 484-628-8252.

#### Charges

Per Pennsylvania Law, 42 PA. C.S. §6152, we may charge for copying records. \*Please do not send payment with your request, if payment is required you will receive a bill in the mail.