Main Line Health®

Pt Name _____

DOB _____

MR # _____

Patient ID

Mirmont Treatment Center/Mirmont Outpatient Services

RELEASE OF INFORMATION AUTHORIZATION

Section I: PATIENT INFORMATION

I hereby authorize Main Line Health/Mirmont Treatment Center/Mirmont Outpatient Services ("Main Line Health") to release medical information from the records of:

Patient Name: _____ D.O.B.: _____

Address: _____ Phone: _____

City/State/ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Section II: RECIPIENT INFORMATION

This information is to be disclosed to (check applicable box and complete information below):

- ☐ Emergency contact
- ☐ Insurance company/managed care organization
- ☐ Laboratory
- ☐ Legal
- ☐ Referral source/Employee Assistance Program
- ☐ Treatment provider
- ☐ Primary Care Physician office
- ☐ Pharmacy
- ☐ Other (please specify): _____

Name of Person or Institution: _____

Address: _____

City/State/ Zip Code: _____

Email Address: _____ Phone: _____

Fax: _____

Preferred Delivery Method:

- ☐ Hard Copy Pick Up
- ☐ Telephone
- ☐ Fax (HIM: emergent purposes only)
- ☐ Hard Copy Mail Delivery
- ☐ Secure MLH My chart Electronic Portal
- ☐ Face-to-face/Verbal exchange
- ☐ Encrypted Email Or 3rd Party Portal (print address clearly): _____
- ☐ Other: (Please specify _____)

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Section III: PURPOSE OF DISCLOSURE AND INFORMATION TO BE DISCLOSED

Purpose of disclosure of information (check all applicable items):

☐ Personal use ☐ Insurance claim(s) ☐ Legal issues

☐ Follow-up care / continuity of care ☐ Medical record update ☐ Treatment authorization

☐ Other (please specify): _____

Information to be disclosed (check all applicable items to be released):

Drug/Alcohol Abuse Information

- ☐ Presence in treatment
- ☐ Prognosis
- ☐ Nature of treatment program
- ☐ Progress in treatment
- ☐ Relapse to use and frequency of relapse

Other information

(May include Mental Health and/or Drug/Alcohol Abuse Information)

- ☐ History and Physical
- ☐ Treatment Plans
- ☐ Intake Documentation
- ☐ Discharge Documentation/Summary
- ☐ Psychiatric Evaluation
- ☐ Medication Information
- ☐ Therapy Notes
- ☐ Progress Notes
- ☐ Diagnosis Code
- ☐ Presence in Treatment
- ☐ Prognosis
- ☐ Nature of treatment program
- ☐ Progress in Treatment
- ☐ Entire Record

☐ Other (please specify): _____

I understand that any information released pursuant to this request will not include any information related to testing or treatment I have received for AIDS/HIV unless box checked.

☐ Release ALL AIDS/HIV related information except as specified below:

Specific information NOT to be disclosed is the following: _____

_____

_____

_____

_____

Section IV: EFFECTIVE DATE OF AUTHORIZATION AND REVOCATION

This authorization will automatically expire in twelve (12) months unless otherwise specified below, or earlier revoked. If applicable, specify other expiration date (not to exceed twelve (12) months): _____.

Except to the extent that action has already been taken to comply with this request, this authorization may be revoked:

(1) in writing at any time, by writing to: Main Line Health, Health Information Management Department, 3809 West Chester Pike, Suite 110, Newtown Square, PA 19073; or

(2) verbally, by speaking directly with a representative of Mirmont Treatment Center (if current patient) or Main Line Health, Health Information Management Department at 484-476-1701

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RELEASE OF INFORMATION AUTHORIZATION

Section V: PATIENT RIGHTS AND OTHER IMPORTANT INFORMATION

- You do not have to sign this Authorization Form. If you refuse to sign, it will not affect your ability to obtain treatment, or your eligibility for benefits (if applicable). However, your decision to refuse to give or revoke authorization may result in your insurance company not being able to pay for your care, and you may be responsible for payment of your claim.
- You have the right to inspect the material to be released, subject to the limitations imposed by Pennsylvania regulations, 55 Pa. Code Section 5100.33.
- Main Line Health will provide a disclosure statement along with all records it releases.
- If applicable, for any information relating to drug or alcohol abuse or dependency, Main Line Health will disclose, with your consent, only the following information to judges, probation and parole officers, insurance companies, health or hospital plan or government officials: (1) whether or not you are still in treatment; (2) your prognosis; (3) the nature of the program; (4) a description of your prognosis; and (5) a statement regarding whether you have relapsed and the frequency of any relapse.
- Prohibition of Re-disclosure: Federal regulations prohibit any further disclosures of drug or alcohol abuse or dependency information except with specific written consent of the person to whom it pertains or as otherwise permitted by such regulations and Pennsylvania Law.
- Main Line Health may deny the request to inspect the material being released under limited circumstances as provided for under state or federal regulations governing the protection of personally identifiable health information. Except as otherwise permitted under applicable federal law, you have the right to have a denial of your request reviewed by a licensed health care professional selected by Main Line Health who did not participate in the decision to deny your request.
- Main Line Health will notify you of its decision to approve or deny your request to access or obtain a copy of the requested information within thirty (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the requested information in not maintained on-site. If Main Line Health is unable to comply with your request within the specified timeframes, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
- In accordance with federal and Pennsylvania state law, Main Line Health may charge you for obtaining copies of records, except for copies sent directly to a healthcare facility or physician for continuing care purposes. Main Line Health will bill you directly for any charges incurred. An invoice will be mailed to you and payment will be expected prior to the records being copied or released.
- You are entitled to receive a copy of this Authorization Form.

Section VI: PATIENT CONSENT

Main Line Health®

Pt Name _____

DOB _____

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Mirmont Treatment Center/Mirmont Outpatient Services

RELEASE OF INFORMATION AUTHORIZATION

Written Consent to Release of Health Information:

I have read and understand this Authorization Form and the nature of my release of health information from Mirmont Treatment Center and Mirmont Outpatient Services and I authorize Main Line Health to disclose my health information in the manner described above.

Signature of Patient or Authorized Representative	Date
Printed Name of Authorized Representative (if applicable)	Relationship to Patient
Signature of Witness	Date
Printed Name of Witness	Date

Verbal Release of Mental Health Information:

Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____ was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

Signature of Witness	Date	Signature of Witness	Date
Printed Name of Witness		Printed Name of Witness	

A copy of this Authorization Form must be offered to patients when Main Line Health initiates the authorization request, or when the authorization pertains to drug and/or alcohol treatment records.

☐ I would like a copy of this Authorization Form

☐ I would not like a copy of this Authorization Form

Main Line Health®

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DOB _____

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Mirmont Treatment Center/Mirmont Outpatient Services

RELEASE OF INFORMATION AUTHORIZATION

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM

1. Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion.

2. The patient or legally authorized representative (see #5 below) must sign and date the form.

3. Please mail the form to Main Line Health
   Health Information Management
   3809 West Chester Pike, Suite 110
   Newtown Square, PA 19073;
   or fax it to 610-356-3531;
   or e-mail it to MLHePatientInfo@MLHS.org.

4. Records will be sent directly to the party listed as the recipient on the Authorization Form. We do not fax records to recipients unless needed for emergent patient care by another healthcare provider.

5. The following is a list of persons authorized to sign the disclosure of health information form:

   - **Patients who are 18 years of age or older:**
     - If the patient is competent, then the patient must sign. No one else is authorized to sign.
     - If the patient is incompetent, then the legal representative must sign and provide appropriate documentation (e.g., a photocopy of power of attorney documents or other legal documents establishing the authority of the legal representative).
   - **Patients who are between 14 and 18 years of age:**
     - If the patient received mental health treatment and consented to his/her own treatment, then the patient must sign.
     - If the patient received mental health treatment and the patient's legal guardian consented to the patient's mental health treatment:
       - The patient may sign; or
       - The legal guardian may sign if he/she is requesting: (a) the release of records to the patient's current mental health treatment provider, (b) the release of records to the patient's primary care provider (as deemed appropriate by patient's current mental health treatment provider); or (c) if the information is necessary for the legal guardian to consent to the patient's mental health treatment.
     - If the patient received drug/alcohol treatment, then the patient must sign.
   - **Patients who are under 14 years of age:**
     - If the patient received mental health treatment, the patient's legal guardian must sign.
     - If the patient received drug/alcohol treatment, then the patient must sign.
   - **Patients who are deceased:**
     - The patient's legal representative must sign and provide appropriate legal proof (e.g., a photocopy of executor documentation).

Please contact Main Line Health, Health Information Management at 484-476-1701 if you have additional questions or need further assistance.