Main Line Health®

☐ Mirmont Treatment Center at Lima
☐ Mirmont Outpatient Services at Broomall
☐ Mirmont Outpatient Services at Exton
☐ Mirmont Outpatient Services at Lima
☐ Women's Emotional Wellness Center

Pt Name _____

DOB _____

MR # _____

Patient ID

LIMITED AUTHORIZATION TO RELEASE INFORMATION

Section I: PATIENT INFORMATION

I hereby authorize MAIN LINE HEALTH to release medical information from the records of:

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

Address: _____ Phone: _____

City/State/Zip Code: _____

Covering the period(s) of care (list applicable dates of treatment): _____

Section II: PURPOSE OF DISCLOSURE AND INFORMATION TO BE DISCLOSED

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

***May include Mental Health and/or Substance Use Disorder Information**

☐ Entire Record

☐ History and Physical ☐ Therapist Notes ☐ Discharge Documentation/Summary ☐ Progress Notes

☐ Intake Documentation ☐ Medication Information ☐ Diagnosis Code ☐ Psychiatric Evaluation

☐ Treatment Plan ☐ Presence in Treatment

☐ 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 specifically checked below:

☐ Release AIDS/HIV related information

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

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

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

☐ Other (please specify): _____

Section III: RECIPIENT OF INFORMATION

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

☐ Emergency contact ☐ Legal representation ☐ Treatment provider

☐ Insurance company/managed care organization ☐ Referral source ☐ Primary care physician office

☐ Laboratory ☐ Employer/employee assistance program ☐ Pharmacy

☐ Other (please specify): _____

Name of Person or Institution: _____

Address: _____

City/State/Zip Code: _____

E-Mail address: _____ Phone: _____

Fax: _____

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Preferred Delivery Method:

☐ Release to encrypted USB

☐ Release the requested information into my MyChart

☐ Release as printed paper copy & pick-up

☐ Release as printed paper copy & mail

☐ Fax: _____

☐ Encrypted Email or Third-Party Portal: _____

Section IV: EFFECTIVE DATE OF AUTHORIZATION AND REVOCATION

This authorization will expire (enter date or specific occurrence): _____. The statement "end of the treatment," "none," or similar language is sufficient. If no end date is specified, this authorization will expire twelve (12) months from date of signature.

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, 3803 West Chester Pike, Ste. 160, Newtown Square, PA 19073; or

(2) verbally, by speaking directly with a representative of Main Line Health, Health Information Management Department, at 484-476-1701.

After Main Line Health receives your notice to revoke, it will terminate this authorization form within 5 business days. Prior to such termination, Main Line Health may have shared some or all your information or otherwise acted in reliance on this authorization form; neither the organization nor any of its representatives are liable for any release of information during such time.

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.
- Once Main Line Health discloses your health information to the recipient, Main Line Health cannot guarantee that the recipient will not re-disclose this information to a third party or as required by law. The third party may not be required to comply with this Authorization Form or applicable law pertaining to the use and disclosure of your health information.
- 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 30 days of receiving this request if the information is maintained or accessible on-site or within 60 days if the requested information is 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 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.

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Section VI: PATIENT CONSENT

Written Consent to Release of Health Information:

I have read and understand this Authorization Form and the nature of my release of health information, 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

For staff use only:

_____ _____
Signature of Staff Member Obtaining/Processing Consent | Date

_____
Printed Name of Staff Member Obtaining/Processing Consent

INSTRUCTIONS FOR COMPLETING THE
LIMITED AUTHORIZATION TO RELEASE INFORMATION FORM

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

2. The patient or legally authorized representative (see #7 below) must sign and date the form.

3. Please mail the form to Main Line Health, Health Information Management, 3803 West Chester Pike, Ste. 160, Newtown Square, PA 19073; 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.