DOYLESTOWN HOSPITAL
595 WEST STATE STREET
DOYLESTOWN, PENNSYLVANIA 18901
Phone: (267) 885-1599 Fax: (215) 489-7235

AUTHORIZATION FOR ACCESS TO ANOTHER PATIENT'S RECORDS "myHealthDoylestown"

Completed authorization forms are returned to ***Medical Records Patient Portal Office****.*

Patient's Name: _____

Patient's Date of Birth: _____ Patient's Telephone: _____ _____ _____

Patient's Address: _____

Patient's E-Mail Address: _____

Patient's Last 4 Digits of Social Security #: ____ ____ ____ ____

I understand that:

a) My medical record may contain information of a sensitive or extremely private nature, including, but not limited to, a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.
b) This authorization may be revoked/ modified at any time by writing to HIS of Doylestown Hospital except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
c) The hospital will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
d) Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
e) I understand that I cannot be compelled to authorize release of any of my medical records.

Authorized User's Name: _____

Authorized User's E-Mail Address: _____

Authorized User's Date of Birth: _____

I am patient, parent, or legal guardian, and authorize person listed above to access this patient record on myHealthDoylestown patient portal. By signing authorization, I also confirm that I am 18 years old or older and have the right to authorize access to this patient record.

_____ (Patient, parent, or legal guardian signature)
Signature used to authorize above person's access to patient's online medical record

_____
Date

Relationship to patient: _____
(e.g. patient, parent, legal guardian, Power of Attorney)

Revised: 6/26

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