

Authorization to release medical records

Use only when a specific records authorization is needed

Patient name

Date of birth

Use only if requested. Complete one form per sender and recipient.

Organization or person authorized to release records

Sender address

Sender phone or fax

Organization or person allowed to receive records

Recipient address

Recipient phone or fax

Purpose ☐ Continuing medical care ☐ At my request ☐ Other described below

Other purpose if applicable

Dates of records requested

Records requested

☐ Wound notes ☐ Medicines and allergies ☐ Labs or cultures ☐ Imaging

☐ Operative or discharge reports ☐ Clinical photos ☐ Other below

Specific records or limits

Excluded: HIV-related information; 42 CFR Part 2 substance use disorder records; separately protected mental health records; and psychotherapy notes. A separate legally appropriate consent or process is needed for these records.

Delivery requested

☐ Secure electronic transfer ☐ Mail ☐ Fax after number verification ☐ Pick up

Expiration date or event (required)

I authorize the release above. I may revoke in writing by delivering a signed request to the sender at the address above. Revocation applies when received and does not undo prior disclosures made in reliance on this form.

Signing is optional and is not a condition of my treatment, payment, enrollment, or benefits. A recipient may redisclose information that HIPAA no longer protects; other protections may apply. I am entitled to a copy of this signed form.

Patient or authorized representative signature

Date and time

Printed name and representative authority if applicable

Parent guardian or personal representative

Complete only when someone is acting for the patient

Patient name

Date of birth

Staff will verify who may act for the patient. Being a relative or caregiver alone does not establish decision-making authority.

Representative full name

Relationship to patient

Address

Phone

Email if used

Basis for authority

- ☐ Parent of minor ☐ Court appointed guardian ☐ Health care power of attorney
☐ Other legal authority

Document or legal basis and effective dates

Limits custody restrictions or conditions that apply

Documents available

- ☐ Attached ☐ Already on file ☐ Will provide ☐ Staff to determine if needed

Staff will check Pennsylvania law, custody restrictions, and any independent right of the minor to consent. This form does not override the minor's confidentiality rights.

An adult with decision-making capacity generally makes their own choices. A representative acts only as legally authorized; financial power of attorney alone may not authorize health care decisions.

Advance care documents

- ☐ Advance directive ☐ Health care power of attorney ☐ POLST or other medical orders
☐ None ☐ Not sure

I state that this information is accurate and will report changes. This form identifies claimed authority; it does not create or expand it.

Representative signature

Date and time

Staff verification

Identity and authority reviewed by

Date

Scope of authority capacity assessment or referral for review

Consent for a specific wound procedure

Complete with the treating clinician before the procedure

Patient name

Date of birth

Proposed procedure and wound location or side

Treating clinician

Planned date

Condition being treated and expected benefit

The clinician must discuss and document individual risks. Examples include pain, bleeding, infection, tissue injury, delayed healing, scarring, allergic reaction, and further treatment. The risks below must be specific to the planned procedure and patient.

Material risks specific to this procedure and this patient

Reasonable alternatives including no procedure and their risks

Numbing medicine or anesthesia plan and relevant risks

Questions preferences or limits expressed by the patient

The procedure, benefits, material risks, alternatives, and effects of declining were explained in language I understand. My questions were answered. No result is guaranteed. I may withdraw before the procedure. I consent only to the procedure identified above.

Patient or authorized representative signature

Date and time

Representative name and authority if applicable

Clinician: I discussed the individualized information above, answered questions, and verified capacity and authority to consent. This page documents the discussion; it does not replace it.

Clinician signature

Date and time

Interpreter name or ID if used

Witness if required by policy

Do not sign an incomplete form. Add a procedure-specific supplement when needed.