YORK GENERAL

PDAPHI

Patient Directed Request for Pharmacy Records

Complete this form to release your YGH Pharmacy records to you or your designee stated below.

Patient Name:_____ Date of Birth: _____/_____/_____

Address:_____City:_____ State:_____ Zip:_____

Phone:_____

I request my Pharmacy records from York General to be disclosed:

☐ to Self and/or the following:

Recipient Name	Relationship to you	Address	Telephone

This form authorizes the patient (age 19 or over) or above listed recipients to pick up York General Hospital pharmacy records from the York General Hospital pharmacy.

To receive any other York General medical records please contact the HIM department.

This authorization form automatically expires 12 months after original date of request:

I understand once my PHI has been released, it is no longer protected by the federal privacy regulations. I may **revoke or change** this request at any time by submitting a request in writing to the Privacy Officer at York General Hospital.

_____ _____

Signature of Patient or Authorized Representative Date

(Must provide copies of Legal paper work for legal representative)

_____ _____

Print Name Relationship to Patient (if applicable)

For Staff Use Only

(When releasing records, have the patient fill out this form or if there is already a continuous authorization on file, print it from their chart, fill out the chart below and route the completed form to HIM for record keeping.)

Date Released	Released By:	Released to:	Encounter Number: