Patient Name: _____
Chart Number:_____
Date: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

****Please read and complete all items****

Patient Name: _____ Alias/ Maiden Name: _____

Date of Birth: _____ Last 4 of Social Security Number: _____ Phone Number: _____

Address: _____

I authorize the use/ disclosure of health information about me as described below:

☐ To obtain from: _____
(what organization)

Address: _____
_____

☐ To disclose to: _____
(release to whom)

Address: _____
_____

The following information from my medical record (*Please specify visit dates*) From _____ to _____

☐ **Complete Medical Record**
☐ **Abstract of Hospital Medical Record** (History & physical, discharge summary, consultation reports, operative & procedure reports, laboratory, imaging reports, and all diagnostic studies)
☐ **Individual Results Listed Above (please specify):** _____
☐ **Physician Office Notes**
☐ **Imaging Films and/ or CDs**
☐ **Billing Statements**
☐ **Other (please specify):** _____

Outpatient Behavioral Health Reports:

☐ **MH Progress Notes** ☐ **Psychiatric Evaluation** ☐ **Psychological Evaluation**
☐ **Medication Check Visits** ☐ **Other (please specify):** _____

For the purpose of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Eligibility/ Benefits**
☐ **Changing Physicians** ☐ **Legal Investigation** ☐ **Billing Inquiries**
☐ **Establish Payment Plan** ☐ **Other (please specify):** _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/ obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records: ☐ Yes ☐ No Dates: _____
HIV Testing and Results: ☐ Yes ☐ No Dates: _____
Mental Health or Psychotherapy Records: ☐ Yes ☐ No Dates: _____

- I understand that if the use/disclosure of these records is for my own use, I may be charges for the pages in accordance with Pennsylvania Department of Health Regulations and the Health Insurance Portability and Accountability Act.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.
- I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Family First Health. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- **This authorization does not expire, unless otherwise specified as follows: _____**
  (Not to exceed 1 year from today)

_____ _____
Signature of Patient/ Responsible Party Date

_____ _____
Print Name of Patient/ Responsible Party Date

_____ _____
Signature of Staff Person Obtaining Authorization Date

SITE:

☐ George Street Center ☐ Nurse Family Partnership ☐ Social Services ☐ Hannah Penn
☐ Gettysburg ☐ Hanover ☐ Lewisberry ☐ Columbia

If patient is unable to consent or is a minor, complete the following:

If signed by a person other than the patient, select relationship. Legal documentation may be required.

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal authority: ☐ Legal Guardian ☐ Custodial Parent ☐ Power of Attorney for Healthcare
☐ Executor of Estate of Deceased ☐ Authorized Legal Representative

Note: My signature acknowledges that I or my representative received a copy of this document. This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

☐ Patient Offered Copy and Received ☐ Patient Will Access Via Portal ☐ Patient Offered Copy and Declined

VERBAL AUTHORIZATION: This portion to be completed when a patient is unable to give written consent.

We, the undersigned, do verify that the above authorization has been read to the client and that he/she has indicated understanding the nature of the authorization and freely gives his/her verbal consent for the release of the above information.

_____ _____
Signature of Responsible Person Date

_____ _____
Signature of Responsible Person Date

REQUESTS FOR HEALTH INFORMATION ARE PROCESSED BY:

CIOX HEALTH