FAMILYFIRST HEALTH

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 SSN:	Phone:
Address:		

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

☐ **To obtain from:** _____ (what organization)	☐ **To disclose to:** _____ (release to whom)
Address: _____ _____	Address: _____ _____

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

☐ Complete medical record	☐ Abstract medical record (History and physical, discharge summary, consultation reports, operative and procedure reports, laboratory, imaging reports, and all diagnostic studies.)
☐ Individual results (please specify):	
☐ Physician office notes	
☐ Imaging files and/or CDs	
☐ Billing statement	
☐ Other (please specify):	

Outpatient Behavioral Health Reports:

☐ MH progress notes	☐ Psychological evaluation
☐ Medication check visits	☐ Psychiatric evaluation
☐ Other:	

For the purpose of:

☐ Further medical care	☐ Personal	☐ Insurance eligibility/benefits
☐ Changing Physicians	☐ Legal investigation	☐ Billing inquiries
☐ Establish payment plan	☐ Other:	

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 and 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 protect 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)

Patient/responsible party signature:	Date:
Patient/responsible party print:	Date:
Staff person obtaining authorization signature:	Date:
Site (Circle one): Columbia Center, George Street Center, Gettysburg Center, Hannah Penn Center, Hanover Center, Lebanon Center, Lewisberry Center **Service/Program** (If applicable): Caring Together, Nurse-Family Partnership, Connections for a Healthy Pregnancy	

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 ☐ Executer 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/received	☐ Patient will access via portal	☐ Patient offered copy/declined

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<u>Verbal Authorization</u>: This portion is to be completed when the patient is unable to given 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:

HEALTHMARK GROUP