2860 Carol Road • York PA 17402
Phone: (717) 757-3400 • Fax: (717) 757-3702

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my protected health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

PATIENT'S FULL NAME: ***(Please Print)*** ______________________________

BIRTHDATE: ______/______/______ SOCIAL SECURITY #: ______-______-______

Please Check (✓) One: ☐ ***SEND PHI TO*** ☐ ***RECEIVE PHI FROM***

____
Name & Address of Health Care Provider / Health Plan Sending / Receiving Protected Health Information

____

____

Check (✓) Description of PHI: *Dates of Service* __________ *to* __________

☐ *Complete Medical Records* ☐ *Lab/Imaging Reports* ☐ *Progress Notes/Office Notes*
☐ *Consultations* ☐ *History & Physicals* ☐ *Operative Reports*
☐ *Emergency Reports* ☐ *Hospitalizations* ☐ *Other* __________

Check (✓) Purpose of Disclosure:

☐ *Disability Application* ☐ *Legal Request* ☐ *Referral Appointment*
☐ *Moving Out of Area* ☐ *Change of Insurance*
☐ *At Patient's Request ⇒ Must have reason:* ______________________________
☐ *Transfer of Care ⇒ Must have reason:* ______________________________
(To continually improve our services, please provide the reason for transfer of care above)

You must read and initial the following statements:

To the extent that any of the following information is contained in the records being released, I hereby authorize the release of such information by checking each category and initialing the appropriate statements.

1. HIV/AIDS related information, including test results, referrals and treatment notes:
   - ☐ I **DO** consent to have this information disclosed. **Initials:** _____
   - ☐ I **DO NOT** consent to have this information disclosed. **Initials:** _____
2. Drug & Alcohol Abuse related information, including test results, referrals and treatment notes:
   - ☐ I **DO** consent to have this information disclosed. **Initials:** _____
   - ☐ I **DO NOT** consent to have this information disclosed. **Initials:** _____
3. Mental Health related information, including test results, referrals and treatment notes:
   - ☐ I **DO** consent to have this information disclosed. **Initials:** _____
   - ☐ I **DO NOT** consent to have this information disclosed. **Initials:** _____

Continued to Other Side ⇨

EXPIRATION DATE: *I understand that this authorization shall expire 12 months from the date requested unless specified with an alternate expiration date. I choose to assign an alternate expiration date of ______/______/______.*

RIGHT TO REVOKE: *I understand that I may revoke this authorization at any time by notifying Pediatric Health Associates in writing. A revocation will not impact any actions taken prior to our receipt of the revocation in reliance on this authorization.*

RIGHT TO NOT SIGN: *I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Pediatric Health Associates, nor will it affect my eligibility for benefits.*

RE-DISCLOSURE NOTICE: *I understand that the information disclosed may be protected by Federal and State confidentiality laws. Therefore, I prohibit you from making any further disclosures unless further disclosure is expressly permitted by written consent of the person to whom it pertains.*

My signature acknowledges that I have read and fully understand this authorization, and authorize use and disclosure of protected health information about the named patient as described. My signature authorizes the release of such information to be sent by mail or fax. A copy of this document may be used in lieu of an original. I understand that Pediatric Health Associates does charge to copy and send medical records, which may be my financial responsibility.

Signature of Patient/Guardian or Personal Representative ______________________ Date ______________

Print Personal Representative's Name ______________________ Relationship to Patient ______________

Signature of Staff Person Obtaining Authorization ______________________ Date ______________

THIS SECTION 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 patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

A verbal consent requires signatures of two witnesses.

Signature of Witness ______________________ Date ______________

Signature of Witness ______________________ Date ______________

(To Be Completed By Authorized Personnel)

Approved By:	Copied By:	Date Invoice Sent:
Date Payment Received:	Date Copies Sent	Completed By:

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS COMPLETED IN ITS ENTIRETY.