PentaHealth

FAX: 610-594-2625

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Patient Name:** _____ ***Date of Birth:** _____

***Address:** _____ **Phone #** _____

***I authorize** _____ *Phone_____ *Fax Number:_____

TO RELEASE MY MEDICAL RECORDS TO: ___MYSELF OR ___OTHER

***Name** of Person, Doctor, Hospital, Agency or Other to where information is to be sent:

_____

***Address** to where information should be sent: _____

*City/Town: _____ State: _____ Zip: _____

*Phone:_____ * Fax Number:_____

Is Patient a minor? ☐ Yes ☐ No
If yes, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
If yes, Legal documentation provided ☐ Yes ☐ No

The information to be shared for the following purpose: ☐ Sharing with other health care providers as needed ☐ Moving

☐ Other (please describe)
_____

ATTENTION PATIENT

I understand and authorize the release of this information unless noted below as an exception. I also understand that my record may contain:

- AIDS/HIV-related information, if AIDS/HIV-related tests were ordered by my physician - Confidentiality of HIV-Related Information Act, PA Law Act 148
- Mental Health information, if mental health treatment was given by my physician - PA Mental Health Procedure Act
- Drug or alcohol information, if drug and alcohol tests were ordered or treatment provided by my physician–Drug & Alcohol Abuse Control Act 42 CFR Part 2

PLEASE RELEASE THE FOLLOWING:

Last Visit_____ Past 2 years_____ Entire Chart_____ OR

The information to be released will cover the time period from_____to_____

EXCEPTION: I do not give permission to release ☐ HIV/AIDS, ☐ Mental Health and ☐ Drugs or Alcohol Information

- I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I acknowledge that the information disclosed pursuant to this authorization may be subject to disclosure by the recipient.
- I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon and that this consent will remain in force in order to effectuate the purposes for which it is given unless revoked by me.
- I understand that my authorization will remain in effect for a period of **90 days** from date of my request.

*_____ *_____ Patient Identity Verified

Patient's Signature **Date** ☐ Yes ☐ No

_____ _____

Signature of Authorized Person / Relationship Date

☐ Unable to sign due to: _____

* **Indicates items that MUST be completed.** Updated 10/01/2020