PUBLIC HEALTH management corporation

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Please Circle a Health Center Below:

CARE CLINIC CONGRESO HEALTH CONNECTION MARY HOWARD RISING SUN

I HEARBY AUTHORIZE PHMC HEALTH CENTERS TO RELEASE/DISCLOSE MY HEALTHCARE INFORMATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DOB	SSN

ADDRESS	APT/SUITE#	CITY	STATE	ZIP

PERSON OR ENTITY AUTHORIZED TO RELEASE/DISCLOSE HEALTH INFORMATION

NAME/ENTITY	PHONE #	FAX#

ADDRESS	APT/SUITE#	CITY	STATE	ZIP

SPECIFIC INFORMATION TO BE RELEASED/DISCLOSED

DATE OF SERVICE (s)

☐ Consult ☐HIV/AIDS ☐Mental Health/Psychiatric/Mental Retardation
☐ Drug or Alcohol Abuse ☐Labs ☐Office Visit
☐History & Physical ☐Medication
☐Other Sensitive Information (specify)

THIS INFORMATION IS TO BE USED FOR THE FOLLOWING PURPOSE (S)

SIGNATURE OF PATIENT/LEGAL GUARDIAN	DATE
PRINT NAME OF PATIENT/LEGAL GUARDIAN	DATE

VERBAL CONSENT

WITNESS 1	DATE
WITNESS 2	DATE

STAFF IDENTIFICATION
NAME OF PERSON OBTAINING CONSENT
Initial Applicable Statement(s)
(Initial)_____ RELEASE OF MENTAL HEALTH RECORDS "This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains." 55Pa.Code section 5100.34(d)
(Initial)_____ DISCLOSURE OF CONFIDENTIAL HIV-RELATED INFORMATION "This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose." 35 Pa. State section 7607(e).
(Initial)_____ RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."
This authorization form will expire 1 year from ____/____/____ (Initial)_____ I understand that I may revoke this authorization by notifying PHMC in writing at the above listed address. (In order to revoke this verbal consent, the patient must understand the nature of the revocation and freely give his or her verbal revocation, as verified in writing by two responsible witnesses.)

Send all Release of Information requests to:

Health Information Management Department

Centre Square East

1500 Market Street, LM

Philadelphia, PA 19102

Fax: 215.985.2677