Green Hill Family Health Center
503 Bridge Street
New Cumberland, PA 17070

PATIENT AUTHORIZTION FOR RELEASE OF INFORMATION

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

Patient Name: ____________________________________________Date of Birth: __________________
Patient Address: __________________________________________________________________________
Phone:_______________________
Name/Address of organization(s) or person(s) providing the information: _________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
Phone:___________________________________ Fax: _______________________________________
Name/Address of organization(s) or person(s) receiving the information: _________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
Phone:___________________________________ Fax: _______________________________________
Specific description of information disclosed:________________________________________________

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials:_____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented.
Initials:_____ Drug and/or alcohol diagnosis, treatments, tests results and reports and referral information.
Initials:_____ Mental health treatment information, test results, and reports including psychological and psychiatric studies, reports, evaluations and referral information.
Initials:_____ Venereal disease information.
Initials:_____ Genetic testing, test results, counseling reports, treatments, and referral information.

You must read and initial the following statements:
Initials:_____ I understand this Authorization will expire on ___/___/___(DD/MM/YR) or on the following event: Termination of the Physician/Patient relationship.
Initials:_____ I understand that I may revoke this Authorization at any time by notifying this office in writing, but if I do, it will not have any effect on any actions this practice took before the received the revocation.

________________________________________ ___________________________ ____________
Signature of Patient or Representative Relationship to Patient Date

________________________________________ ____________________________
Witness Signature Date