## PENNSYLVANIA AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

□ All AIDS/HIV-Related Record □ Limited AIDS/HIV-Related as follows: □□ Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively)  Purpose of Release of Information: □ Transferring Medical Care □ Moving □ Other □□ One year unless otherwise specified, this authorization will expire 1 year after the date of this request.  1. This authorization will expire: □ Date: □□ Event: □□ One year unless otherwise specified, this authorization will expire 1 year after the date of this request.  2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation.  3. This authorization is voluntary.  4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.  5. I understand that this information may be re-released by the recipient and no longer protected.  6. By signing below, I certify that I understand the nature of this Release.  7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.  8. If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.  9. If AIDS or HIV-related information is being released, 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	I,,HEREBY AUTHORIZE THE RELEASE OF	F MY HEALTH INFORMATION AS LISTED BELOW
Provider or facility authorized to release information:	Patient Name:Date o	of Birth:
Provider or facility authorized to release information:  Address (street, city, state, zip)  Person or entity authorized to receive information:  Address (street, city, state, zip)  Dates of Service:   All   Specific Dates of Services:  Description of Information:   Entire Record   Others:  Description of Information:   Beneficial Records: Include the following medical records if such information is included in your records. Checking the poxes is not a representation that such information exists. (See waiver below).  Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)  Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)  Include AIDS/HIV - Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)  Include AIDS/HIV-Related Record   Limited AIDS/HIV-Related as follows:  Include Sexual Abuse/Assult and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively)  Purpose of Release of Information:   Transferring Medical Care   Moving   Other    Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the date of this request.  Lunderstand that I may revoke this authorization will expire 1 year after the	Address (street, city, state, zip):	
Address (street, city, state, zip)  Person or entity authorized to receive information:  Address (street, city, state, zip)  Dates of Service:   All   Specific Dates of Services:  Description of Information:   Entire Record   Others:  Special Records: Include the following medical records if such information is included in your records. Checking the poxes is not a representation that such information exists. (See waiver below).  Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)  Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)  Include AIDS/HIV - Related Record   Limited AIDS/HIV-Related Information Act, 35 P.S. § 7607)  All AIDS/HIV-Related Record   Limited AIDS/HIV-Related as follows:  Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 5116, respectively)  Purpose of Release of Information:   Transferring Medical Care   Moving   Other    1. This authorization will expire:   Date:   Date:   Date:   Date:   One year unless otherwise specified, this authorization will expire 1 year after the date of this request, unless otherwise specified, this authorization will expire 1 year after the date of this request, unless otherwise specified, this authorization at any time by notifying my provider or by notifying the provider or entity that is authorization surforated to receive the information is not a health pan or health care provider, the information may no longer be protected. Inderstand that revocation will not have any effect on actions taken prior to any revocation.  3. This authorization is voluntary.  4. I understand that if the organization authorized to neceive the information is not a health pan or health care provider, the information may no longer be protected by decral privacy regulations.  5. By signing below, I certify that I understand the nature of this Release.  7. I understand that if the organization a	Telephone:	
Person or entity authorized to receive information:    Address (street, city, state, zip)	Provider or facility authorized to release information:	
Address (street, city, state, zip)	Address (street, city, state, zip)	
Description of Information:   Entire Record   Others:	Person or entity authorized to receive information:	
Description of Information:   Entire Record   Others:	Address (street, city, state, zip)	
Description of Information:   Entire Record   Others:		
Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. (See waiver below).  Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108) Include Maintal Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111) Include AIDS/HIV – Related Record (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)    All AIDS/HIV – Related Record   Limited AIDS/HIV-Related as follows:	Dates of Service.   All Specific Dates of Services.	
Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71   P.S. § 1690.108)   Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)     Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)     Include AIDS/HIV – Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)     All AIDS/HIV-Related Record   Limited AIDS/HIV-Related as follows:	Description of Information: ☐ Entire Record ☐ Others:	
Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)  Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)  Include AlDS/HIV - Related Record   Limited AlDS/HIV-Related Information Act, 35 P.S. § 7607)    All AlDS/HIV-Related Record   Limited AlDS/HIV-Related as follows:	Special Records: <u>Include the following medical records if such informatio</u> boxes is not a representation that such information exists. (See waiver be	n is included in your records. Checking the
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□ All AIDS/HIV-Related Record □ Limited AIDS/HIV-Related as follows: □ Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively) Purpose of Release of Information: □ Transferring Medical Care □ Moving □ Other □	- '	Act, 50 P.S. § 7111)
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1. This authorization will expire: Date: Event: One year unless otherwise specified, this authorization will expire 1 year after the date of this request.  2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation.  3. This authorization is voluntary.  4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.  5. I understand that this information may be re-released by the recipient and no longer protected.  6. By signing below, I certify that I understand the nature of this Release.  7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.  8. If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.  9. If AIDS or HIV-related information is being released, 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.  10. By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.  1. This waiver is applicable only to this request and is not meant to be a general waiver.  1. Printe		
Printed Name of Patient's Representative/Guardian Relationship to the Patient	<ol> <li>unless otherwise specified, this authorization will expire 1 year after th.</li> <li>I understand that I may revoke this authorization at any time by notifying that is authorized to receive these records. I understand that revocationary revocation.</li> <li>This authorization is voluntary.</li> <li>I understand that if the organization authorized to receive the information formation may no longer be protected by federal privacy regulations. I understand that this information may be re-released by the recipient of the secondary of the secondary recipient information by signing below, I certify that I understand the nature of this Release. I understand that the provider named above may not condition treatment whether I sign this authorization.</li> <li>If mental health records are being released as permitted by the Mental right subject to 55 Pa. Code § 5100.33, to inspect the material to be respected by the information in the pennsylvania law. Pennsylvania law prohibits you from making any further disclosure is expressly permitted by the written consent of the person of Confidentiality of HIV-Related Information Act. A general authorization not sufficient for this purpose.</li> <li>By signing below, I authorize the release of the medical informatic confidentiality protection afforded by Pennsylvania statutory law</li> </ol>	e date of this request. In many provider or by notifying the provider or entity on will not have any effect on actions taken prior to sion is not a health plan or health care provider, the and no longer protected.  The ent, payment, enrollment or eligibility for benefits on a least
Date Conjed & Notified:	Signature of Patient or Patient's Representative/Guardian  Printed Name of Patient's Representative/Guardian	

