New Patient Information Form (8.2018) **Today's Date**:____/_____/_____

Patient Legal Last Name:_____ **Patient Middle Initial**:_____

Patient Legal First Name:_____

Patient Preferred Name: ☐ Same as Legal Name ☐ Different- **Preferred Name**:_____

Patient's Pronoun/s: ☐ He/him ☐ She/her ☐ They/them ☐ Other:_____

Patient Date of Birth: ____/_____/_____ **Patient Social Security Number:**_____-_____-_____

What is your PRIMARY ADDRESS: **Street:**_____

City/State/Zip:_____

What is your PRIMARY PHONE #:_____ **Type of PRIMARY phone?** ☐ Home ☐ Cell ☐ Work

What is your ALTERNATE PHONE #:_____ **Type of ALTERNATE phone?** ☐ Home ☐ Cell ☐ Work

What is your email address:_____

Patient's Sex for/with Health Insurance: ☐ Female ☐ Male ☐ Unknown/Other

Patient's Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Unknown/Other

Patient's Sexual orientation (SO/GI): ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual

☐ Don't know ☐ Choose not to disclose ☐ Other: specify _____

Patient Gender: ☐ Female ☐ Male ☐ Transgender FTM (Female to Male) ☐ Transgender MTF (Male to Female)

☐ Non-Binary Gender ☐ Choose not to disclose ☐ Other Gender Identify:_____

EMERGENCY Contact Name:_____ **ER Contact Phone #**_____

ER Contact Address:_____

Relationship to Emergency Contact(e.g. mom, spouse, etc.):_____

Patient's Marital Status: ☐ Divorced ☐ Married ☐ Partnered ☐ Single ☐ Unknown ☐ Widowed ☐ Separated

Language Translation: Does the patient require a translator and/or translated written materials?

☐ No, I am proficient in English ☐ Yes, if yes, in what language:_____

Patient's Race: ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Other ☐ Decline to Specify

☐ Asian **(check ALL that apply)** ☐ Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

☐ Native Hawaiian/Pacific Islander **(check ALL that apply)** ☐ Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other

Patient's Ethnicity: ☐ Not Hispanic or Latino ☐ Decline to Specify

☐ Hispanic or Latino **(check ALL that apply)** ☐ Mexican/Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Patient's Housing Status: (☐check one) ☐ Stable/Permanent ☐ Temporary ☐ Unstable ☐ Homeless

OTHER (☐check ALL that apply)

☐ Patient is a **Veteran** ☐ Patient is a **Migrant Worker** ☐ Patient is a **Seasonal Worker**

MEDICAL INSURANCE

Does the patient have Primary Insurance coverage?

☐ No- NO Primary Insurance

☐ Yes- Primary Insurance is →

Primary Insurance Name: _____

Primary Insurance Number: _____

Does the patient have Secondary Insurance coverage?

☐ No- NO Secondary Insurance

☐ Yes- Secondary Insurance is →

Secondary Insurance Name: _____

Secondary Insurance Number: _____

PHARMACY

Patient's Pharmacy Name:_____ **Pharmacy #:**_____

Pharmacy Address:_____

INCOME

What is your **SOURCE** of household income? **(☐check ALL that apply)** ☐ **N/A NO INCOME**

☐ Salary/Wages/Employment
☐ Alimony
☐ Private Disability
☐ CASH ASSISTANCE from Public Asst/Welfare
☐ Other SOURCE of INCOME:_____
☐ Social Security (SSI/SSD/SSA-Retirement)
☐ Child Support
☐ Pension
☐ Private Retirement

What is your **AMOUNT**of household income per **YEAR** ? _____ per **MONTH**? _____

What is your **SIZE** of household (NUMBER OF PEOPLE)? _____

Do you have proof of income with you today?

☐ Yes- (if yes HAND IN PROOF OF INCOME with this form) ☐ No (COMPLETE NEXT QUESTION)

If you do NOT have Proof of Income, Why? ☐ Forgot to bring ☐ Lost/Do not Have ☐ Income is $0

☐ Refused (Refusal may result in ineligibility for discounts and benefits) ☐ Other:_____

I certify that the above household and income information is true and correct to the best of my knowledge.

Patient/ Patient's Guardian's Signature:_____
Date:_____

CASE MANAGEMENT

Does the patient have a Case Manager? ☐ No ☐ Yes (If yes, complete information below)

Case Manager Name:_____ **Case Manager Phone #**_____

Case Manager Agency/ Organization:_____

Patient Communication Consent Form

Patient Legal Name: _____

Patient DOB: _____ Date: _____

EMAIL, VOICEMAIL, and TEXT MESSAGE COMMUNICATION VIA THE INTERNET

EMAIL, VOICEMAIL, and TEXT MESSAGE COMMUNICATION VIA THE INTERNET DISCLAIMER: This form is used to obtain your consent to communicate with you by Email, Voicemail, or Text Messaging (also called Short Message Service/SMS), transmitted through the internet and regarding your protected health information (PHI), or the protected health information of the patient you are legally authorized to represent (e.g. your child, someone for whom you are a legal guardian, etc.). Philadelphia FIGHT Community Health Centers offer patients and their legal representatives/guardians the opportunity to communicate by E-mail, Voicemail, and Text Messaging which is transmitted via the internet. Information transmitted through the internet has a number of risks that patients and their legal representatives/guardians should consider before granting consent to use E-mail, Voicemail, or Text sent through the internet for these purposes. Philadelphia FIGHT Community Health Centers will use reasonable means to protect the security and confidentiality of E-mail, Voicemail, and Text information sent and received. However, Philadelphia FIGHT Community Health Centers cannot guarantee the security and confidentiality of E-mail, Voicemail, and Text communication and will not be liable for inadvertent disclosure of confidential information to a third party**.**

Can we EMAIL you via the internet, including email messages that may contain your or the patient's Protected Health Information, at the email address or addresses you provide to us?
SELECT ONE → ☐ NO ☐ YES

Can we send you VOICEMAIL messages via the internet, including voicemail messages that may contain your or the patient's Protected Health Information, at the phone number or numbers you provide to us?
SELECT ONE → ☐ NO ☐ YES – If yes, what is the preferred phone number for VOICEMAIL(_____) _____-_____

Can we TEXT you via the internet, including text messages that may contain your or the patient's Protected Health Information, at the phone number or numbers you provide to us?
SELECT ONE → ☐ NO ☐ YES– If yes, what is the preferred phone number for TEXT(_____) _____-_____

What is your language preference for messages? **SELECT ONE** → ☐ English ☐ Spanish

In addition it individualized messages from your medical provider or other members of your care team at FIGHT, you can also chose to receive AUTOMATED REMINDERS. Would you like to: receive automated reminders about:
CHECK ALL THAT APPLY ☐ **Appointments** ☐ **Lab Results** ☐ **Health Maintenance**
☐ **Prescription Confirmations** ☐ **General Notifications (such as weather closings)**

PATIENT ACKNOWLEDGEMENT AND AGREEMENT: I acknowledge that I have read and fully understand the Email, Voicemail, and Text Message via the internet Disclaimer, above. I understand the risks associated with communication of E-mail, Voicemail, and Text via the internet between Philadelphia FIGHT Community Health Centers and myself, and/or those I represent. I consent to the conditions outlined above. I agree and consent that Philadelphia FIGHT Community Health Centers may communicate with me regarding my protected health information, or that of the patient I represent, by E-mail, voicemail, or text sent via the internet. I understand that I have the right to revoke this consent, at any time, by sending written notification to Philadelphia FIGHT Privacy Officer, 1233 Locust St. 5th FL., Philadelphia PA, 19107.

Patient or Legally Authorized Representative Signature:

Signature:	**Date:**
Print Name:	
If a Legally Authorized Representative signed this form, describe the relationship: (e.g. parent, legal guardian, Power of Attoney, etc.)	

PHILADELPHIA FIGHT COMMUNITY HEALTH CENTERS

Authorization to Release of Protected Health Information By Patient or Legally Authorized Representative to Patient's
EMERGENCY CONTACT/PRIMARY SUPPORT PERSON

A health record is private and contains information known under the law as "Protected Health Information(PHI). By completing and signing this form, I, or the person I am legally authorized to represent, agree to allow Philadelphia FIGHT Community Health Centers to share my or the patient's PHI with the people or entities listed below. I agree that by Philadelphia FIGHT Community Health Centers, I mean all employees, staff, students and other FIGHT personnel who have access to any health information, about me or the patient I represent, received or created in the provision of health care. Additionally I understand that Philadelphia FIGHT Community Health Centers, includes, but is not limited to: the Jonathan Lax Treatment Center, John Bell Health Center, Y-HEP Health Center, Pediatric Health Center, Clinica Bienstar, Broad Street Ministry Health Center, or a Philadelphia FIGHT HIV and/or Hepatitis C testing, the Diana Baldwin Clinic, Tree IOP and Dental Services.

1. Patient Information

Patient First Name:	Patient Last Name:	Middle Initial:	Patient Date of Birth: / /

2. Philadelphia FIGHT Community Health Centers can share my or patient's PHI with the following people or entities

Primary Support Person or Emergency Contact Name:	Support/ER Contact Phone Number: ( ) -
Person Support Person or Emergency Contact Address:	Support/ER Relationship (e.g. mom, spouse, etc.)

3. Information to be released by Philadelphia FIGHT Community Health Centers

Information to be released: Any and all Protected Health Information, including but not limited to, Treatment, Diagnoses, Medications, Labs, Hospitalizations, Appointments and Adherence.

This Protected Health Information is to be released for the following purposes: Coordination of care with patient's primary support person/ emergency contact related to patient's medical treatment and engagement in medical care, BOTH in emergency and NON-EMERGENCY situations.

I understand that information related to the following may only be released if I specifically order its release.
(Check all that apply, to agree to release information related to HIV, Substance Abuse, and/or psychotherapy notes)

- ☐ I agree to release information **related to HIV.**
- ☐ I agree to release information **related to Substance.**
- ☐ I agree to release information **related to Mental Health Treatment.**

4. This authorization shall be in force and effect for 5 (five) years from the date of signature at which point this authorization expires.

5. By signing below I understand and agree:
That Philadelphia FIGHT Community Health Centers may release my or the patient's PHI within the terms outlined above. That I have been given the opportunity to review Philadelphia FIGHT's Notice of Privacy Practices. I understand that I have the right to revoke this authorization, at any time, by sending written notification to 1233 Locust St. 5th Floor, Philadelphia PA 19107. I understand that a revocation is not effective to the extent that Philadelphia FIGHT Community Health Centers has relied on my authorization to disclose protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or state law. I understand that HIV related information is protected by Pennsylvania law (see notice below). I understand that I have the right to receive a signed copy of this authorization. I understand that I have the right refuse to sign this authorization and that my refusal will not affect my right to treatment.

6. Patient or Legally Authorized Representative Signature:

Signature:	Date: / /
Print Name:	Phone Number: ( ) -
If a Legally Authorized Representative signed this form, describe the relationship: (e.g. parent, legal guardian, Power of Attoney, etc.)	
If this request is being signed by a patient's Legally Authorized Representative, you must provide legal documentation authorizing you to act on the patient's behalf.	

Notice: 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.

Philadelphia FIGHT Community Health Centers

Revision 03/2018; Board Approved 03/28/2018

CONSENT FOR TREATMENT AND RELEASE OF HEALTH INFORMATION

NAME OF PATIENT: _____ Date: _____
Patient's Date of Birth:_____

FOR LEGALLY AUTHORIZED REPRESENTATIVES WHO ARE COMPLETING THIS CONSENT ON BEHALF OF A PATIENT:
Name of Legally Authorized Representative: _____
Legally Authorized Representative's Relationship to Patient:_____
(e.g. Parent, Legal Guardian)

1. **CONSENT FOR TREATMENT:** I, as the patient or patient's legally authorized representative, hereby consent to the performance of such diagnostic procedures and/or medical treatment, including the administration of blood products, as deemed necessary or advisable by the physician/s and/or health care provider/s at the Jonathan Lax Treatment Center, John Bell Health Center, Y-HEP Health Center, Pediatric and Adolescent Health Center, Clinica Bienstar, Broad Street Ministry Health Center and /or Philadelphia FIGHT Dental Services (all entities referred to collectively as the Philadelphia FIGHT Community Health Centers). I hereby consent to the performance of all nursing and technical procedures and tests as directed by these physician/s and/or health care provider/s.

2. **COMPLIANCE WITH RULES AND REGULATIONS:** In consideration of treatment, I agree to abide by the rules of the Philadelphia FIGHT Community Health Centers.

3. **ASSIGNMENT OF BENEFITS:** As the patient or patient's legally authorized representative, I hereby make the assignment of benefits as set forth below:

   MEDICARE AND/OR MEDICAID: I authorize any holder of medical, dental or other protected health information about me, the patient, or about the patient that I am legally authorized to represent, to release this information to Medicare and/or Medicaid. This information is disclosed for the purpose of billing and obtaining payment for care and for obtaining authorization for necessary treatment. I hereby authorize direct payment to Philadelphia FIGHT for medical, dental and/or surgical benefits from Medicare and/or Medicaid. I also permit a copy of this authorization to be used in place of the original.

   GENERAL AUTHORIZATION: I authorize any holder of medical, dental or other protected health information about me, the patient, or about the patient that I am legally authorized to represent, to release this information to any another medical practice or medical provider involved in my, or the patient's care. This information is disclosed for the purpose of billing and obtaining payment for care, for obtaining authorization for necessary treatment and for coordination of care.

   I authorize any holder of medical and/or dental information or other protected health information about me, the patient, or about the patient that I am legally authorized represent, to release this information to my or the patient's insurance company, the intermediaries or carriers, and/or to my or the patient's attorney. This information is disclosed for the purpose of billing and obtaining payment for care. I hereby authorize direct payment to Philadelphia FIGHT for medical, dental and/or surgical benefits from my or the patient's private insurance company or other health plans. I also permit a copy of this authorization to be used in place of the original.

4. **IMMUNIZATION INFORMATION SYSTEM:** I authorize the physician/s and/or health care provider/s and/or public health agency to collect and enter my immunization records, or the immunization records of the patient I am legally authorized to represent, into the Department of Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as all my or the patient's health care providers to assist in medical care and treatment. In addition, information may be released to other facilities at which I, or the patient, am enrolled as a patient to comply with state immunization requirements.

5. **PHARMACY BENEFITS STATEMENT:** A "Pharmacy Benefits Statement" (PBM) is a statement that shows all medications that have been processed through an insurance company for any period of time regardless of the prescriber. I authorize Philadelphia FIGHT to view my PBM, or the PBM of the patient I am legally authorized to represent, download my or the patient's PBM, and make it an ongoing part of my or the patient's electronic medical records.

NAME OF PATIENT: _____ Patient's Date of Birth:_____

6. **CLINICAL TRIALS ELIGIBILITY SCREENING:** Philadelphia FIGHT conducts clinical trials of new and potential treatments for different disease states. Additionally, FIGHT studies various factors related to these disease states such as prevention of diseases and treatment adherence. The purpose of this research is the overall goal of improving health outcomes. I authorize Philadelphia FIGHT health care provider/s and/or Philadelphia FIGHT research staff to review my medical/dental chart, or the medical/dental chart of the patient I am legally authorized to represent, and contact me if a clinical trial is appropriate for or the patient. This is not authorization to enroll myself or the patient in any trial and I understand that I or the patient is not obligated to participate in any research.

7. **FINANCIAL ASSISTANCE/SLIDING FEE PROGRAM:** I understand that if I, as the patient, am uninsured or underinsured, or the patient I legally represent is uninsured or underinsured, financial assistance may be available. If I need assistance I can contact the Health Centers' benefits coordinators or medical case managers for further information about financial assistance for uninsured or underinsured patients. I understand that I will need to provide timely information to verify my or the patient's eligibility for sliding fee/financial assistance. I understand that my or the patient's application for financial assistance/sliding fee expires one year from the date of the original application and to continue receiving financial support I must reapply if the application has expired.

8. **FAMILY PLANNING:** Receipt of family planning services is not a prerequisite to receipt of any other services offered at this health center.

9. **NOTICE OF PRIVACY PRACTICES AND GRIEVANCE PROCEDURES:** **(PLEASE INITIAL)**

   _____ INITIALS **Acknowledgment:** I acknowledge that I have been given and received a copy of the Philadelphia FIGHT Notice of Privacy Practices and Grievance Procedures. I have been given the opportunity to review both documents and agree to their contents.

   If I have a concern about Philadelphia FIGHT Notice of Privacy Practices and Grievance Procedures, I may contact Mimi McNichol, by phone: (215) 985-4448 ext. 223, by email: mcnichol@fight.org, or by mail: 1233 Locust Street, 5th floor, Philadelphia, PA, 19107.

Initial the appropriate line below if YOU are below the age of 18 years old and consenting for yourself

_____ I am seeking treatment for sexual and reproductive health services (except abortion)
_____ I am seeking treatment for substance abuse
_____ I am seeking treatment for mental health
_____ I am seeking treatment, and disclosure of treatment to my guardian/s would subject me to abuse or neglect
_____ I am seeking treatment and I am a high school graduate
_____ I am seeking treatment and I am married or I was previously married
_____ I am seeking treatment and I am pregnant or I was previously pregnant (regardless of whether or not the pregnancy resulted in the birth of a child)
_____ I am seeking treatment and I am emancipated (meaning you are legally emancipation or you, as a minor, have left your parent/guardians household by agreement or demand)

BY MY SIGNATURE, I CERTIFY THAT I AM THE PATIENT OR LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-9 OF THIS DOCUMENT, UNDERSTAND ITS CONTENT, AND AGREE TO ITS TERMS. I UNDERSTAND THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PRINTED NAME of Patient or Legally Authorized Person:_____

Signature of Patient or Legally Authorized Person_____ Date:_____

TO PHILADELPHIA FIGHT STAFF: ALL HIV-RELATED INFORMATION FOUND IN PATIENT RECORDS IS PROTECTED BY PENNSYLVANIA'S CONFIDENTIALITY OF HIV-RELATED INFORMATION ACT, KNOWN AS ACT 148. YOU ARE PROHIBITED FROM DISCLOSING THIS INFORMATION WITHOUT THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, UNLESS OTHERWISE PERMITTED BY LAW. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

Patient's Bill of Rights and Responsibilities

Philadelphia FIGHT

Parents and Legal Guardians/Representatives: When used in this document the word "you" or "your" in this notice, means any person about whom we have any medical information that we received or created in our capacity as a health care provider. If any such person is a minor or has a legal guardian or other personal representative, then, as to those persons, this notice is directed to the minor's parent, or to the legal guardian, or other personal representative, but "you" and "your" refer to the minor or person who is unable to consent for themselves.

Philadelphia FIGHT is committed to empowering clients and patients to make healthy choices. In order to maintain a safe space for the Philadelphia FIGHT community and staff we expect everyone to uphold the following rights and responsibilities:

RIGHTS

As a patient of Philadelphia FIGHT:

- You have the right to be treated with dignity and respect.
- You have the right to appropriate medical, nursing and case management services, without discrimination based upon your race, ethnicity, beliefs, gender identity or expression, sexual orientation, socio-economic status, and/or disability.
- You have the right to a non-judgmental and safe place free from drugs, violence, sexual harassment and weapons.
- You have the right to be an informed participant in decisions relating to your medical care.
- You have the right to say yes to treatment. You also have the right to say no or refuse treatment.
- You have the right to request to work with another staff member, or terminate your involvement with the Philadelphia FIGHT at any time.
- You have the right to have your records and confidentiality protected from disclosure within the law.
- You have the right to review your records with your nurse, medical provider, or case manager and get copies when needed.
- You have the right to speak with a supervisor about any questions, problems or concerns regarding your services (please refer to Philadelphia FIGHT grievance procedure).

RESPONSIBILITIES

As a patient of Philadelphia FIGHT:

- You have the responsibility to treat EVERYONE (other clients, staff, etc.) with dignity and respect.
- You have the responsibility to respect the confidentiality of ALL other clients.
- You have the responsibility to maintain a non-judgmental and safe space for yourself and others free from drugs, violence, sexual harassment and weapons.
- You are responsible for your actions if you refuse treatment or do not follow your treatment plan proposed by your medical provider or case manager.
- You have the responsibility to provide accurate and complete information relevant to the services being provided to you.
- You have the responsibility to inform us of any address or telephone changes, hospitalizations, or other significant changes and to initiate regular contact with us if you are unable to be reached by phone. We may have medical or case management information for you that needs to be acted upon in a timely manner.
- You have the responsibility to schedule appointment times in advance and attend those appointments on time.

Failure to meet these expectations will result in denial and possible termination of services at Philadelphia FIGHT

Patient Name: _____ **Patient Date of Birth**:_____
(Printed Name)

IF APPLICABLE: Name of Parent/Legal Guardian: _____
(Printed Name)

Patient or Parent/Legal Guardian Signature: _____

Date: _____

REVISED 3.9.18

Authorization for Designated Agents

This form is for a Parent/Legal Guardian of children/minors (who cannot consent to their own medical care). By completing this form a Parent/Legal Guardian can designate individuals to accompany their child or children for medical services when the Parent/Legal Guardian is unable to do so.

The child/children, for whom I authorize the following agent/s, are:

(Please list the Name and Date of Birth for each Child/Minor that you wish to designate an agent/s for)

1.Name of Child/Minor/Patient: _____ Date of Birth _____
2.Name of Child/Minor/Patient: _____ Date of Birth _____
3.Name of Child/Minor/Patient: _____ Date of Birth _____
4.Name of Child/Minor/Patient: _____ Date of Birth _____

(If more than 4 children please request an additional form)

I hereby give permission to the following person/s to bring the child/minor patient into Philadelphia FIGHT Health Centers for medical care and to receive confidential medical information about the patient.

(Please list the individual/s you wish to designate as authorized agent/s **(MUST BE 18 OR OLDER)** to bring child/children in for care)

1. _____ _____ _____ _____
Designated Agent Name | Agent Date of Birth | Agent Phone Number | Agent Relationship to Child/Children

2. _____ _____ _____ _____
Designated Agent Name | Agent Date of Birth | Agent Phone Number | Agent Relationship to Child/Children

3. _____ _____ _____ _____
Designated Agent Name | Agent Date of Birth | Agent Phone Number | Agent Relationship to Child/Children

I, _____, give the above person/s permission to bring my child/children
(Printed Name of Parent/Legal Guardian)
to Philadelphia FIGHT Community Health Centers to receive medical treatment and to make medical decisions on behalf of my child/children as well as to receive confidential medical information about my child/children. I understand and agree that:

- **Confidential medical information includes all information contained in my child/children's medical record and any and all information that relates to my child/children's current or future medical treatment including but not limited to insurance records regarding any such services.**
- **Any person I designate as an authorized agent will also be designated and authorized as an alternate emergency contact for my child/children.**
- **Individual/s or person/s I have authorized as designated agent/s for my child/children must bring government issued photo identification with them, when accompanying my child/children for medical care**
- **This authorization will remain in effect until changed by the parent/legal guardian signed below**
- **This form will be scanned into my child/children's medical record.**
- **I understand that I have the right to revoke this authorization, at any time, by sending written notification to: Philadelphia FIGHT Privacy Officer, 1233 Locust St. 5th FL., Philadelphia PA, 19107 OR by requesting a copy of this form from the PFCHC clinic where I receive services, completing the "Revocation" section at the bottom of this form, and returning to that PFCHC clinic.**

By signing I affirm that I have reviewed, understand, and agree to the authorizations and terms listed above.

PRINTED Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature _____ Date _____

AUTHORIZATION REVOCATION

I, _____ hereby revoke the above authorization. This revocation is effective upon my signature and receipt of this revocation by Philadelphia FIGHT Community Health Centers.
(Printed Name of Authorization Signatory)

PRINTED Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature _____ Date _____

1207 Chestnut Street, 5th Floor, Philadelphia, PA 19107 Phone: (215) 525-8600 Fax: (215) 564-0484

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth _____ SSN _____

Authorization is given to Philadelphia FIGHT Community Health Centers Pediatrics, 1207 Chestnut Street 5th Floor, Philadelphia PA 19107, to ☐ release to ☐ receive from ☐ release to/obtain from

_____ _____
Name of Organization *Address*

_____ _____ _____ __
Phone *Fax* *Contact Name*

Information to be disclosed: ☐ Educational records (i.e. IEP, disciplinary record, evaluation report) ☐ Medical Summary ☐ Complete Medical Record ☐ Last 3 Visits ☐ Growth Chart ☐ Dental Summary ☐ Discharge Summary ☐ Vaccination Records ☐ Other _____

This protected health information is disclosed for the following purposes: ☐ Continuity of Care ☐ Verbal Communication ☐ Referral ☐ Other _____

I understand that information related to the following may only be released if I specifically order its release.

- **I agree** ☐ to release information **related to HIV.**
- **I agree** ☐ to release information **related to substance abuse.**
- **I agree** ☐ to release information **related to Psychotherapy notes.**

This authorization shall be in force and effect until _____ at which time this authorization expires.

- I have been given the opportunity to review Philadelphia FIGHT's Notice of Privacy Practices. I understand that I have the right to revoke this authorization by sending written notification to 1233 Locust St. 5th Floor, Philadelphia PA 19107. I understand that a revocation is not effective to the extent that the Pediatric Center has relied on my authorization to disclose protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or state law. I understand that HIV related information is protected by Pennsylvania law (see notice below).

I understand that I have the right to:

- Receive a signed copy of this authorization.
- Refuse to sign this authorization and that my refusal will not affect my right to treatment.

X _____ X _____
Signature of Patient/Parent/Guardian Date

X_____
Name of Parent/Guardian and relationship to patient

Witness Signature _____ Date _____

Notice: 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.