Philadelphia FIGHT Community Health Centers

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I am a patient, or a patient's legally authorized representative, of Philadelphia FIGHT Community Health Centers. By signing below, I authorize Philadelphia FIGHT to Disclose my protected health information ("Information") as described below. I understand that signing this Authorization is voluntary.

Patient Information:

Patient First and Last Name:_____ Patient Date of Birth:_____

Authorization is given to Philadelphia FIGHT Community Health Centers to

☐ **Release Information to:**

☐ **Receive Information from:**

Person or Entity Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information to be Disclosed:

☐ Entire Medical Record **OR** *Check All Applicable Below*

☐ Labs ☐ Diagnostic Report

☐ Medication List ☐ Other (*specify*) _____

Are there date restrictions on the Information to be Disclosed?

☐ No ☐Yes (*specify the timeframe of the records*):_____

Purpose(s) of Disclosure:_____

The patient or the patient's Legally Authorized Representative agrees with the following statements:

I understand that, unless prohibited by Act 148 or other applicable state law, the Information Disclosed may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics.

If you do NOT wish for this specific information to be Disclosed, please describe the category(ies) of information to be excluded:_____

1. I understand my treatment, payment, enrollment or eligibility for benefits will not be affected if this Authorization is not signed.
2. I understand that this Authorization will expire upon this date or event: _____ or in 5 years after the date of my signature if no other date or event is listed, unless the authorization is sooner revoked.
3. 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 Floor, Philadelphia PA 19107.
4. I understand that revoking this authorization will not have any effect on any actions taken before Philadelphia FIGHT received the revocation.
5. I understand that there is potential that the recipient of the Information may redisclose the Information and the Information may no longer be protected by federal or state privacy laws.
6. I understand that I have the right to receive a signed copy of this authorization.

_____ _____

Signature of patient or patient's Legally Authorized Representative Date

(Form MUST be completed before signing.)

Printed name of Patient's Legally Authorized Representative: Description of Legal Authority to act for the Patient:

_____ _____