***Infectious Diseases Associates, P.C.***

***729 Grove Avenue, Suite 4, Southampton, PA 18966-6008***

***215-355-9634 Fax 215-357-7540***

**AUTHORIZATION FOR ACCESS OR RELEASE OF PROTECTED HEALTH INFORMATION**

**Section A: This section must be completed on all Authorizations**

**Patient Name: Birth Date: Social Security #:**

**Address:**

**City: State: Zip Code:**

**Release Information to:**

**Name:**

**Address:**

**City: State: Zip Code:**

**This Authorization will expire on the following date:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of Disclosure:**

**Description of Information to be Used or Disclosed**

Is this request for psychotherapy notes? □ Yes, then this is the only item you can request on this authorization. You must submit another authorization for other items below. □ No, then you may check as many items below as need **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description: Date(s): Description: Date(s): Description:**

□All PHI in medical record \_\_\_\_\_\_\_\_\_ □Operative Information \_\_\_\_\_\_\_\_ □ Other: All information

□Test Results or Reports \_\_\_\_\_\_\_\_\_ □Pathology Reports \_\_\_\_\_\_\_\_ needed to complete the form that

□ Correspondence □ER Information \_\_\_\_\_\_\_\_ I have provided:

□Progress Notes \_\_\_\_\_\_\_\_\_ □Itemized bill for DOS \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Physician Orders □ER Information \_\_\_\_\_\_\_\_ ie. Disability, FMLA

**□Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge and hereby consent that the released information that I have requested may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.\_\_\_\_\_\_\_\_\_\_ (Initial here to grant consent for release of thisspecificinformation).

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that:**

**1**. I may refuse to sign this authorization and that it is strictly voluntary

**2**. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization

**3**. I may revoke this authorization at any time in writing, but if I do, it will not have any on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

**4**. If the requester or the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed

**5**. I understand that I may see and/or obtain a copy of the information that I have authorized for release. If I request a copy of the information, I will be charged a copy fee.

**6**. I will receive a copy of this form after I sign it.

**7**. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

**Section B:** I authorize the facility, its employees, officers and physicians to discuss my PHI with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the above and authorize the disclosure of the protected health information as stated:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Authorized Representative Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name of Patient Witness** **Signature**