1202 State Street
Erie, PA 16501
(814) 455-7222
(814) 453-4857 (Fax)

*****If record is more than 25 pages, please mail*****

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize:

Provider/Organization: _____

Address: _____

City/State/Zip: _____ Telephone: ( ) _____ Fax: ( ) _____

To release protected health information contained in the record of:

Patient's Name: _____ DOB: _____ SSN: _____

Address: _____

City/State/Zip: _____Telephone:_____

This protected information to be released to:

Provider/Organization: Community Health Net _____ Relationship: _____

Address: 1202 State Street _____

City/State/Zip: Erie, PA 16501 _____ Telephone: (814) 455-7222 Fax: (814) 453-4857

Information to be disclosed: (One or more boxes must be checked and dates must be specified)

☐ Treatment Notes ☐ Immunizations ☐ Radiology Reports ☐ Therapy Notes ☐ Records from other facilities

☐ Laboratory/Pathology Reports ☐ Physical ☐ Other: _____

Time period for which information to be released can be found in my medical record: ____/_____/_____through _____/_____/_____
(date) (date)

Reason for which I am authorizing: ☐ Continuation of Care ☐ Transfer ☐ Personal Use ☐ Payment of a Claim
☐ Other: _____

I understand that my medical record may contain information (including medications) related to **alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV, and/or AIDS, and/or sexual assault.** This information **WILL BE** disclosed unless otherwise specified. Initial beside the information that you **DO NOT** want released:

_____Alcohol/Drug Abuse and/or Dependence _____Mental Health Other_____
_____HIV and/or AIDS _____Sexual Assault

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to my medical/dental provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on _____/_____/_____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that the information disclosed according to this release may be re-disclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

_____ _____ _____
Signature of patient or legal representative Date Relationship

_____ _____
Witness to Signature Date