Protected Health Information (PHI) Use and Disclosure Authorization

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Name of person or individual: _____
First Name Middle Name Last Name

DOB: _____/_____/_____
Month Day Year

Address:_____

_____

I authorize:_____

to **Receive** protected health information

Address:

_____

_____

****Purpose of Disclosure:** ☐At patient's request ☐Continuing Care ☐Personal Records ☐Legal ☐Insurance ☐Other

Name of Entity or Person(s) to Release Information:

*Name:_____

Address:_____

*Name:_____

Address:_____

***Release of the following information requires specific authorization. Initial by those that apply:**

_____HIV / AID testing / Treatment Records
_____Drug, Alcohol or Substance Abuse Records
_____Mental Health Records (excludes psychotherapy)
_____Genetic Markers
_____Other (disclose the following protected health information):

_____

_____

*I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to the Practice Administrator at 455 Pennsylvania Avenue Suite 105 Fort Washington, PA 19034. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

*I understand that this authorization is effective while I am a patient at Scott A. Fleischer MD, PC, unless a different expiration date is provided

_____/_____/_____(specify new date).

*I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

***Name of patient or Personal Representative** _____
Type/Print

_____ **Date:**_____

_____ ***Signature of Patient or Personal Representative**

_____**Date:**_____

***Description of Personal Representative**

Authority:_____**Date:**_____