Authorization for Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I hereby authorize Community Health and Dental Care *(name of sender)*

Address: 351 W. Schuylkill Road, Suite G-15A, Pottstown, PA 19465   Phone: 610-326-9460   Fax: 610-222-5006

To disclose to: _____ *(name of recipient)*

Address: _____ City: _____ State: _____ Zip _____

Telephone: _____ Fax: _____

Name of Patient: _____ DOB: _____

Check the box and initial to specify which type of information is to be disclosed:

- o Medical Information   _____Start Date   __ to End Date _____
- o X-Ray Results   _____Start Date   __ to End Date _____
- o Lab Results   _____Start Date   __ to End Date _____
- o Progress Notes   _____Start Date   __ to End Date _____
- o Consultation Reports   _____Start Date   __ to End Date _____
- o All Healthcare Information   _____ Start Date   __ to End Date _____

Specify the records to be disclosed

Yes No Initials	I authorize the release of my STD results, HIV/ AIDS testing, whether negative or Initials positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that l must give specific written permission before disclosure of these test results to anyone.
Yes No Initials	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here. _____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient: CHDC Witness:
Signed: _____   Signed: _____
Name: _____   Name: _____
Relationship to Patient: _____   Date: _____