

## **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: <u>351</u>	. W. Schuylkill Road, Suite	G-15A, Pottstown, PA 1946	5 Phone: <u>610-326-9460</u>	Fax: <u>610-222-5006</u>
To disclose to	): 		(/	Name of recipient)
Address:		City:	State: Zip	
Telephone: _		Fax:		
Name of Pation	ent:		DOB:	Marque la casilla y
Check the box	x and initial to specify wh	ich type of information is to	be disclosed:	
Medical Information		Start Date	to End Date	
X-ray Results			 to End Date	
Lab Results			to End Date	
Progress Notes			to End Date	
Consultation Reports		Start Date _	to End Date	
All Heal	thcare Information	Start Date	to End Date	<del></del>
Specify the re	ecords to be disclosed			
Yes No	· · · · · · · · · · · · · · · · · · ·			
Initials	Initials positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I 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.			
of signature u	unless a different date is s This authorization is also s	ubject to written revocation	n by the member/patient	·
upon this aut		' '	<b>31</b> ,	
		cipient may not lawfully fur n me or unless such use or d		nealth information unless equired or permitted by law.
Authorized Representative of Patient: Signed:		CHDC Wit Signed:	ness:	
Name:		Name:		
Relationship to Patient:				