CHDC
Your Health.
Our Community.

Authorization for Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I hereby authorize _____
(name of sender)

_____
Address

_____ ____ _____ _____ _____
City State Zip Telephone Fax

To disclose to Community Health & Dental Care
(name of recipient)
351 W Schuylkill Rd, Suite: G:15A
Address

Pottstown PA 19465 610-326-9460 610-222-5006
City State Zip Telephone Fax

Name of Patient_____ DOB_____

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

- ○ Medical Information _____ Start Date _____to End Date_____
- ○ X-Ray Results _____ Start Date _____to End Date_____
- ○ Lab Results _____ Start Date _____to End Date_____
- ○ Progress Notes _____ Start Date _____to End Date_____
- ○ Consultation Reports _____ Start Date _____to End Date_____
- ○ 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 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.

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.

Type full name here to sign electronically

Authorized Representative of Patient:
Signed_____
Name_____
Relationship to Patient_____

CHDC Witness:
Signed_____
Name_____
Date_____