

Authorization for Release of Medical Information- Personal Health Record Request

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 to specify which type of information is to be disclosed

| | | | |
|--------------------------|-----------------------------|------------------------|--------------------|
| <input type="checkbox"/> | Medical Information | From Start Date: _____ | To End Date: _____ |
| <input type="checkbox"/> | X-ray Results | From Start Date: _____ | To End Date: _____ |
| <input type="checkbox"/> | Lab Results | From Start Date: _____ | To End Date: _____ |
| <input type="checkbox"/> | Progress Notes | From Start Date: _____ | To End Date: _____ |
| <input type="checkbox"/> | Consultation Reports | From Start Date: _____ | To End Date: _____ |
| <input type="checkbox"/> | All Health Care Information | From Start Date: _____ | To End Date: _____ |

Specify the records to be disclosed (Please circle and initial below)

| | |
|------------------------|---|
| Yes or 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 I must give specific written permission before disclosure of these test results to anyone. |
| Yes or 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:

Name (please print): _____ Name (please print): _____
 Signature: _____ Signature: _____
 Relationship to Patient: _____ Date: _____