Authorization to Disclose My Personal Health Information

I authorize the disclosure of my Personal Health Information to the following individuals:

☐ **Family Members:**
Specify Name, Relationship, and Phone Number

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☐ **Caregivers/Other**
Specify Name, Relationship, and Phone Number

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Patient Name: ____

Date of Birth: ________________________ **SS #:** ___________________

- I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include: (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will remain in effect till I revoke it or I transfer from the practice
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

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Signature of Patient or Patient's Legal Guardian **Printed Name of Patient or Legal Guardian**

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Relationship to Patient **Date**

2150 Noll Drive, Suite 100, Lancaster, PA 17603
Phone: (717) 299-8933 | **Fax:** (717) 299-5635 | www.beittelbecker.com