Delaware Valley Community Health, Inc.

# Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____/_____/_____ SS#:_____ MEDICAL RECORD #:_____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

**I hereby authorize Delaware Valley Community Health, Inc. to: ☐ Release or ☐ Obtain information from my: ☐ Medical ☐ Dental record as indicated below: ☐ To ☐ From:**

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

**INFORMATION TO BE RELEASED**:

| | DATES: |
|---|---|
| ❑ History and Physical exam | _____ |
| ❑ Progress notes | _____ |
| ❑ All records | _____ |
| ❑ Lab /X-ray reports | _____ |
| ❑ Other | _____ |
| _____ | _____ |

**I specifically authorize the release of information relating to:**
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X_____/_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

**PURPOSE OF DISCLOSURE:** ____ Changing physicians' ____ Consultation/second opinion ____ Continuing care
___ Legal ____ School ____ Insurance
___ Other (please specify): _____

1. I understand that this authorization will expire in **90 days** (print the date this Form Expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand that I may see a copy of the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that ***DVCH***, ***Inc***., (print name of provider) _____ ☐ will ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information describe above.

_____/ _____ OR _____/ _____
**SIGNATURE OF PATIENT** **DATE** **PARENT/LEGAL GUARDIAN** **DATE**

_____/ _____OR _____/_____
**RECORDS RECEIVED BY** **DATE** **RELATIONSHIP TO PATIENT** **DATE**

***FOR OFFICE USE ONLY***

DATE REQUEST FILLED: _____ BY: _____

TYPE OF IDENTFICATION PRESENTED: _____