Delaware Valley Community Health, Inc.

# Authorization to Release or Obtain Health Information

**Delaware Valley Community Health, Inc. (DVCH)** · Form ROI-001 · Rev. 11/2026

> *Use this form to share your health information with another person or organization, or to have records sent to DVCH.* ***For a copy of your own records, ask for a Records Access Request instead.*** *Psychotherapy notes (ROI-002) and SUD counseling notes (ROI-003) need their own forms. Free interpreter services are available. Formulario disponible en español.*

## 1. Patient

| | | | |
|---|---|---|---|
| **Name** | | **Date of birth** | |
| **Other names used** | | **MRN** | |
| **Phone** | | **Email** | |
| **Address** | | | |

## 2. Who shares and who receives

☐ DVCH (all locations) **releases to** the party below ☐ DVCH **obtains from** the party below ☐ **Both** (exchange)

| | |
|---|---|
| **Person / organization** | |
| **Address** | |
| **Phone / fax** | |
| **Secure email** | |

## 3. Information to share

**Dates:** from _____ to _____ ☐ All dates

☐ Complete record ☐ Visit notes / H&P ☐ Labs ☐ Imaging ☐ Medications, allergies, problem list ☐ Immunizations ☐ Prenatal / OB ☐ Referrals / consults ☐ Dental ☐ Billing ☐ Behavioral health summaries ☐ Other: _____

**Specially protected information: initial for each item to include. Anything left blank will NOT be shared.**

| Initials | Information |
|---|---|
| | HIV/AIDS-related information (PA Act 148) |
| | Substance use disorder (SUD) treatment records (42 CFR Part 2) |
| | Mental health treatment records (PA Mental Health Procedures Act) |
| | Genetic testing |
| | Sexually transmitted infection (STI) testing and treatment |
| | Reproductive health (pregnancy, contraception, options counseling) |

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*If you initialed SUD records:* they may go only to the recipient and for the purpose on this form. A recipient that is a HIPAA covered entity or business associate may redisclose them for treatment, payment, or health care operations as HIPAA allows. Others may not redisclose them without your written consent. They cannot be used against you in any civil, criminal, administrative, or legislative proceeding without your separate consent or a court order.

## 4. Purpose

☐ My request ☐ Continuing care ☐ Referral / second opinion ☐ Insurance / benefits ☐ Disability / SSA ☐ Legal ☐ School / camp ☐ Employment ☐ Other: _____

## 5. Delivery

☐ Patient portal ☐ Secure email ☐ Fax ☐ Mail ☐ Encrypted USB ☐ Pick up (photo ID required)

If none is checked, paper copies are mailed. Regular (unencrypted) email is available on request after staff explain the risks.

## 6. Expiration

Expires on _____ or when this happens: _____. **If left blank, it expires 90 days after I sign.**

## 7. My rights

- **I may revoke** this authorization at any time in writing to the DVCH Compliance Department, Attn. Privacy Officer, [401 W Allegheny Avenue Philadelphia, PA 19133] or via email at complianceofficer@dvch.org. Revocation does not apply to information already shared in reliance on it.
- **My care does not depend on signing.** DVCH will not condition treatment, payment, enrollment, or eligibility on this form. The only exception is a service done only to create information for a third party, such as an employer-paid physical.
- **Once shared,** the recipient may redisclose my information, and it may no longer be protected by HIPAA. HIV, SUD, and mental health information keep their extra protections.
- **I may get a copy** of this signed form and see or copy the information shared.
- **Payment (staff completes):** DVCH ☐ will ☐ will not receive payment from a third party for this disclosure.
- **Copy fees** may apply as Pennsylvania law permits. See the DVCH *Notice of Privacy Practices* for more.

## 8. Signature

| | | | |
|---|---|---|---|
| **Patient signature** | | **Date** | |
| **Representative name** | | **Signature / date** | |

**Representative authority:** ☐ Parent of minor ☐ Legal guardian ☐ Health care POA ☐ Estate executor / administrator ☐ Other: _____ (attach legal document; not needed for a parent of a minor)

**Minors:** For care a minor consented to on their own under Pennsylvania law (pregnancy, STI, contraception, mental health at age 14+, SUD), the minor must sign.

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## Office use only

| | |
|---|---|
| **Received (date / by)** | |
| **ID verified (type)** | |
| **Representative authority verified** | ☐ Yes ☐ N/A |
| **Un-initialed protected items removed** | ☐ Yes ☐ N/A |
| **Notices attached** | ☐ Part 2 ☐ HIV ☐ Mental health ☐ N/A |
| **Sent (date / method / pages / by)** | |
| **Copy given to patient** | ☐ Yes ☐ Declined |

## Attachment A: Redisclosure notices

**SUD records (42 CFR § 2.32):**

> *42 CFR part 2 prohibits unauthorized use or disclosure of these records.*

**HIV-related information (35 P.S. § 7607(e)):**

> *This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.*

**Mental health information (55 Pa. Code § 5100.34):**

> *State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.*