CITY LINE FAMILY MEDICINE

301 East City Avenue, Suite 100, Bala Cynwyd, PA 19004 Phone: (610) 617-1300 Fax: (610) 617-0199

Authorization to Release Protected Health Information

HIPAA Compliant Request for Information

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Name of Patient Phone Number Date of Birth

____

Street Address City State Zip Code Last four digits of SSN

I hereby give the following entity permission to release my Protected Health Information (PHI):

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____
____
____

I instruct the above named entity to produce the following information: (Check ONE only)
____ Release a 2 year abstract of my records ____ Entire Record (subject to state regulated rates)
____ I would like specific records released: ____

I authorize the above listed records to be released to the following entity:

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____
____
____

You must complete the full name and address of where you want your records released.

This authorization expires ninety (90) days from signature, or at the following event: _________________

I am requesting my PHI to be disclosed for the following purpose:__________________(continuing care, change of insurance, referral, etc.)

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above *are to be released through this authorization* unless specified below:
DO NOT RELEASE: (Check all that apply) ___ HIV ___Behavioral Health ___ Drug/Alcohol

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

____ ____________________

Signature of Patient Date

____ ____________________

Signature of Parent/Guardian Date

Any payments are required prior to release.