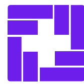

WAYNE MEMORIAL
COMMUNITY HEALTH CENTERS

AUTHORIZATION FOR RELEASE, USE, AND DISCLOSURE OF SENSITIVE INFORMATION

RELEASE TO RECIPIENTS

Your Name ________________________________ **Date of Birth**________________________

Address____ **Telephone**________________________

I hereby authorize **Wayne Memorial Community Health Centers** to release, use, and disclose health information about me as described
below to the following individuals or entities:

☐ MYSELF ☐ OTHER (list addresses below)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

SENSITIVE MATERIALS I authorize release of information about the following sensitive information if it is contained within the medical record: ☐ HIV test results

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

AUTHORIZATION EXPIRATION This authorization is valid (check one):

☐ From today forward for 90 days.

☐ For patient to indicate a **shorter timeframe only**. (specify the dates) – From ________ until ________

REASON FOR DISCLOSURE My health information is being released or disclosed for the following reason(s)
Check all that apply:

☐ Personal ☐ Insurance Eligibility/Benefits ☐ Further medical care

☐ Legal investigation or Action ☐ OTHER (Please specify)____________________________

CONSENT

- I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information disclosed in response to this authorization may be subject to re-disclosure by the recipient, and will no longer be protected under the terms of this authorization.
- I understand I have the right to inspect or copy the health information to be used or disclosed as permitted by law.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable).
- I understand that Wayne Memorial Community Health Centers may receive compensation for medical record copying in accordance with Pennsylvania law, 42 Pa.C.S. § 6152.

X
______________________________ ____________ ______________________
PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE DATE CLEARLY PRINT NAME

X
______________________________ ____________ ______________________
SIGNATURE OF WITNESS DATE CLEARLY PRINT NAME OF WITNESS

Original to Medical Record: Copy to Patient

For Hospital Use Only:

MRN __________Date Received __________Date ID Verified__________Date Processed__________Date Mailed__________