AUTHORIZATION TO RELEASE MEDICAL RECORDS TO THIRD PARTY-2024

Name (print) DOB Last 4 SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:
PHA-Adult Medicine, 1740 South Street, Suite 300, Philadelphia, PA 19146

INFORMATION TO BE SENT TO
Name of Recipient_____ Fax: _____

Address_____ City_____ State _____Zip_____

INFORMATION TO BE RELEASED: (Check one)
___The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
___All Medical records
___Specific information (Please Specify):_____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (Please check one.)
PHA-Adult Medicine will charge for copying records in accordance with Pennsylvania Department of Health Notice and the Health Insurance Portability and Accountability Act. Additional fee may include actual cost of postage, shipping and delivery.

___Attorney OR ___Insurance OR ____Personal Request
2024 Charges: **$1.89** (Pages 1-20) $1.40 (pages 21-60) $0.49 (Pages 61 to end)

___Social Security request/Federal or state needs-based programs $35.50 (flat fee)
___ Search and retrieval fee $28.01 (not charged to patient for personal request)
___District Attorney request $28.01

PATIENT AUTHORIZATION
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. EXCLUDE the following information from the records released (please initial.)

___Sexually transmitted infections ___Drug/Alcohol abuse/treatment & diagnosis
___HIV/AIDS diagnosis/treatment/testing ___Mental illness or psychiatric diagnosis/treatment

My RIGHTS
I understand that my voluntary authorization may be withdrawn at any time, except to the extent that action has been taken based on this authorization. **I understand that this authorization shall expire, without my express revocation, ninety (90) days from the date written below. Information used or disclosed pursuant to this Authorization may be disclosed by the recipient and no longer protected by relevant Federal Law**. I hereby agree to hold Philadelphia Health Associates – Adult Medicine, P.C., its agents, employers, and participating providers free and harmless from any actions against it or them for alleged invasion of privacy, libel, slander, or defamation arising in connection with disclosure of such information. This request may be denied under limited circumstances as provide by Federal Law.

Signature: _____ Date: _____
(Patient, guardian or Authorized Representative)

Verbal Release of Patient Health Information: If the patient is deemed competent but not physically able to provide signature, a verbal consent will be accepted from the patient provided it is witnessed by two people.

"We, the undersigned, certify that _____was physically unable to provide a signature that he/she understood the nature of this release and freely gave his/her consent."

X_____ _____ _____
Signature of Witness #1
X_____ _____ _____
Signature of Witness #2