TriValley Primary Care

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed (Check as applicable):

__ Entire medical record

__ Entire medical record since (date): _____

__ Prescriptions/referrals/lab work ***Pick-up Authorization***

Info related to: (show date)
__ Auto injury _____
__ Phys exam _____

__ Other
_____

2. The information will be used/disclosed for the following purpose(s) (Check as applicable):

__ Record release to other physician (see back if transferring records)
__ Record release to an institution
__ Record release to life or disability insurance co. or employer
__ Other (explain) _____
__ Personal use (a fee may apply)
__ Assist getting reports or medications to me

3. Organizations authorized to use or disclose the information: TriValley Primary Care, **_____Office**

4. Persons/organizations authorized to receive the information (if records release, complete Page 2):

5. (Answer only if TVPC is requesting authority to sell patient's information to a marketer). The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes____ No_____

6. 1 understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, TriValley Primary Care reserves the right to deny treatment associated with such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, TriValley Primary Care reserves the right to deny that health care.

9. I understand that I may inspect or receive a copy of the information used or disclosed.

10. I understand that I may revoke this authorization at any time by notifying TriValley Primary Care in writing, except to the extent that:
    a) action has been taken in reliance on this authorization (that is, the information has already been disclosed); or
    b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or contest the policy itself.

11. I understand that I have a right to request and receive a Notice of Privacy Practices from TriValley Primary Care.

12. This authorization expires on [upon] (Check as applicable): ___ Upon completion of action (one time) ___ Never (on-going) or Give Date: _____ or describe Event which triggers expiration: _____

_____ _____ _____
Signature of Patient or patient's representative | Patient's date of birth (for ID) | Date Signed

_____ _____
Printed name of patient or patient's representative | Relationship to patient, or POA

Office use: Provide copy of this form to patient except where info is for personal use Effective April 11, 2003 Version: 20030411

"A Community of Physicians ... for the Community"

Lower Salford*Pennridge*Upper Perkiomen*Franconia*Lansdale*Western Bucks*Indian Valley

Authorization for Release of Medical Records (Records Out)

Note: To authorize a records release, the patient MUST complete and sign the Authorization for the Use and Disclosure of Individually Identifiable Health Information form on the reverse side (Page 1). **Failure to complete and sign both Page 1 and Page 2 voids this request to transfer records**.

Patient's Full Name: _____
Patient's Social Security Number: _____ Patient's Date of Birth: _____

I hereby authorize the disclosure of all written or oral medical records including, but not limited to, office notes, test results, diagnosis, and prognosis, **including all drug and alcohol abuse counseling, sexual abuse/assault counseling, mental health, and confidential HIV/AIDS related information**, except as noted here:

_____

(please note any specific information that you do not wish to have released.)

Release the above information to:

_____
(Complete name of person/organization who is to receive records)

_____
Address

_____
City, State Zip

If there is a problem, please contact me here:

_____
Phone number

_____
Address

_____
City, State Zip

If transferring records to another provider, please complete the following: (Please check all that apply.)

	Leaving area		Unhappy with service
	Specialized care needed		Insurance coverage changed
	Other(please explain) _____		Please list insurance coverage:

This information is being disclosed to the above named person, organization or agency from records whose confidentiality may be protected by the Drug and Alcohol Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Regulations (Federal Public Law 93-282) and/or Confidentiality of HIV Related Information (Pennsylvania Law, Act 148). My signature below authorizes release of all such information unless otherwise noted above by routine/express mail service, electronic medical records or facsimile transaction.

_____ _____
Signature of Patient or patient's representative Relationship to Patient

_____ _____
Date Witness signature

If records for your children are being transferred, please list each to be transferred: (adults must complete their own form):

	Child's Name	Child's Date of Birth
1		- -
2		- -
3		- -

Please note that the transfer may take up to two weeks to complete.