TriValley Primary Care

Authorization for the Use and Disclosure of Individually Identifiable Health Information – Request for Records

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):

   I have completed a form on Page 2 which says what information is requested. **See Page 2**.

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

   I want my current physician/provider to have a copy of the records described on Page 2.

3. Organizations authorized to disclose the information:

   I have completed a form on Page 2 which says who has the records ("current holder").

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

   I have completed a form on Page 2 which says which TriValley Primary Care office will receive my records.

5. The person/organization authorized to use/disclose the information will receive compensation for doing so.

   Unknown, but if the holder of my records charges for providing them to TriValley, I will pay the charge.

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. Note: TriValley Primary Care charges for providing copies for personal use in most cases.

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) unless otherwise marked**: 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: Keep this form until records are received. Provide a copy to patient only if the current holder charges for sending the records.

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

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

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Authorization for Release of Medical Records (**Records In**)

Note: To authorize a records release, the patient MUST complete and sign the *Authorization for the Use and Disclosure of Individually Identifiable Health Information* – **Request for Records** 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: _____

Current Holder: The following provider, facility, or institution has the records I want transferred to the TriValley Primary Care Office shown below.

Get the records from: _____
(Complete name of person/organization who has my records)

_____
address

_____
city, state, zip

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 **To**: TriValley Primary Care, _____Office
address
city, state, zip

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.

If the Current Holder charges for these records, please contact me via at the "Release To" address above with the charges, before transferring them.

_____ _____
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		- -

Thank you for selecting a TriValley Primary Care provider!