100 N. Hanover St. Carlisle, PA 17013 Phone: 717-218-6670 Fax: 717-218-6671

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name (PRINT)	**Patient's Date of Birth**
Patient's Street Address	**Patient's Social Security Number**
City, State, Zip Code	**Phone Number**

I authorize the use/disclosure of health information about me as described below:

☐ Receive Records from: _____
Name /address of facility/phone number/fax number

☐ Send Records to: _____
Name /address of facility/phone number/fax number

☐ Share the following information from my medical record:

From: _____ to _____
(Please specify the Dates of Service)

☐ Entire Medical Records
☐ Entire Dental Records
☐ Immunization Records
☐ Lab and/or X-ray reports
☐ Other (please specify): _____

Please initial the Protected Health Information to be released. This information will only be released if you initial the applicable sections below:

_____ HIV/AIDS Related Information
_____ Behavioral/Mental Health Services
_____ Drug/Alcohol Addiction and/or Treatment

For the purpose of:

☐ Coordination of Care
☐ Transfer out of practice
Reason for transfer: _____
☐ Personal
☐ Insurance Benefits
☐ Legal
☐ Other (please specify): _____

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I understand the following:

There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.

I understand that if the person or organizations identified above are not health care providers, health plans, or health care clearing houses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such persons and/or organizations may redisclose my health information without obtaining my authorization.

I have had the opportunity to review and understand the contents of this form. By signing this form, I authorize Sadler Health Center Corporation to send/disclose or use/receive my protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. By voluntarily signing this form, I am confirming that it accurately reflects my wishes.

This authorization expires on _____or upon the occurrence of the following event related to my health care or to the purpose for which I have authorized the use and /or disclosure of my health information as follows: _____
I understand that this authorization may be revoked by me at any time in writing except to the extent that action has been taken in reliance upon this authorization. Revocation must be directed to Sadler Health Center Corporation.

This authorization will not be accepted unless it is completed in its entirety.

_____ _____

Signature of Patient **Date** **Relationship of Patient/or Personal Representative**