Sadler Health Center

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:**	❒ **Release Records To:**
Name	Name
Mailing Address (Street, City, State, Zip Code)	Mailing Address (Street, City, State, Zip Code)
Phone Number Fax Number	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): _____

Format in which you would like to release or receive medical information:
❒ Paper (❒ US Mail ❒In-Person Pickup)
❒Fax (providers only)
❒Sadler Health Center Patient Portal

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
_____ Reproductive Health Information
_____ Genetic Testing Results

For the purpose of:

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

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 will remain in effect for one year from the date of signature unless revoked earlier. I understand that I may revoke this authorization at any time by submitting a written request to Sadler Health Center (to the attention of the Health Information Management Department), except to the extent that action has already been taken in reliance on this authorization. I further understand that Sadler Health Center will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

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

Printed Name of Patient or Representative	**Signature of Patient or Representative**	**Date**

Relationship if signed by other than patient