ELKINS PARK HOSPITAL

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Last First Middle
Home Address:	
Home Telephone:	
Date of Birth:	

Specify Information to be Disclosed:

_____

_____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness _____
- ☐ Developmental Disability _____
- ☐ Psychotherapy Notes _____
- ☐ HIV/AIDS Testing or Treatment (regardless of result) _____
- ☐ Venereal Disease _____
- ☐ Abuse of an Adult with a Disability _____
- ☐ Sexual Assault _____
- ☐ Child Abuse or Neglect _____
- ☐ Genetic Testing _____
- ☐ Other _____

RECIPIENT: **Name of person or class of persons to whom ELKINS PARK HOSPITAL may disclose my health information:**

ADDRESS: **Address of the recipient or where my health information should be delivered:**

TERM: **This Authorization will remain in effect:**

- ☐ From the date of this Authorization until the ___ day of _____, 200__.
- ☐ Until Covered Entity fulfills this request.
- ☐ Until the following event occurs _____
- ☐ Other _____

PURPOSE: I authorize ELKINS PARK HOSPITAL to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

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_____

I understand that once ELKINS PARK HOSPITAL discloses my health information to the recipient, ELKINS PARK HOSPITAL cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at ELKINS PARK HOSPITAL; except, however, if my treatment at ELKINS PARK HOSPITAL is for the sole purpose of creating health information for disclosure to the recipient identified in this