Authorization, in which case ELKINS PARK HOSPITAL may refuse to treat me if I do not sign this Authorization.

If my treatment is related to my participation in a research study, I understand that ELKINS PARK HOSPITAL may refuse to treat me if I do not sign this Authorization.

This authorization will remain in effect:

From the date of this Authorization until _____

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to ELKINS PARK HOSPITAL'S Privacy Office at the address listed below. The revocation will be effective immediately upon ELKINS PARK HOSPITAL'S receipt of my written notice, except that the revocation will not have any effect on any action taken by ELKINS PARK HOSPITAL in reliance on this Authorization before it received my written notice of revocation.

I may contact ELKINS PARK HOSPITAL'S Privacy Office by mail at 60 East Township Line Road, Elkins Park, PA 19027, by telephone at 215-663-6979.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize ELKINS PARK HOSPITAL to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Personal Representative Description of Authority Date

SPECIAL AUTHORIZATION FOR RELEASE OF MENTAL HEALTH/REHABILITATION/ALCOHOL-DRUG ABUSE AND HIV TESTING CONTAINED IN PATIENT'S MEDICAL RECORD.

I have been informed of my rights subject to the Mental Health Procedure Act, 1976, (55PA.Code Section 5100.34) to inspect the information to be released, of the confidentiality provisions of section Sc of the PA Drug and Alcohol Abuse Control Act, 1972, which specifically limits disclosure to Medical Personnel exclusively for the purpose of obtaining benefits due to me as a result of my drug or alcohol abuse or drug or alcohol dependence and comply with the Confidentiality of HIV-Related Information Act, 1991, (35 P.S. Section 7607 cc.)

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER 90 DAYS AFTER IT IS SIGNED. THIS CONSENT IS SUBJECT TO REVOCATION, IN WRITING, AT ANY TIME EXCEPT IF ELKINS PARK HOSPITA HAS ALREADY TAKEN ACTION FOR THE DISCLOSURE. IF THE PATIENT IS PHYSICALLY UNABLE TO SIGN, A MINOR, LEGALLY INCOMPETENT, OR DECEASED, PARENT/GUARDIAN MUST SIGN BELOW. TWO WITNESS SIGNATURES REQUIRED FOR VERBAL CONSENT ONLY. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL EXPIRE ON THE

_____ DAY OF _____, 20_____.

Date:_____ Signed:_____

Date:_____ Signed:_____

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____

Signature of employee validating identity