Frankford Hospitals
Jefferson Health System

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____
Last *First* *Middle*

Home address: ____

____

Home telephone: ______________________ Date of Birth ______________

I hereby authorize ______________________________ to disclose to
Name of program or facility making disclosure

____
Name and address of the person/organization to whom the disclosure is being made

____

Specific information to be released: ______________________________

____

Purpose of the disclosure: ______________________________

Highly Confidential Information

Federal and State laws require special privacy protection for certain highly confidential information about you. This includes PHI that is: 1) maintained in psychotherapy notes; 2) documentation related to mental health or developmental disabilities services; 3) drug and alcohol abuse, prevention, treatment and referral information; 4) information related to HIV status, testing, treatment as well as any information related to the treatment or diagnosis of sexually transmitted diseases; and 5) PHI related to genetic testing. Generally, we must obtain your authorization to release this type of information. However there are limited circumstances under the law when this information may be released without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.

Term of Consent

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation is provided to the facility. The revocation will be effective immediately upon receipt of the written revocation except to the extent that the information has already been released.

- ☐ For 90 days from signature of consent
- ☐ Until Frankford Hospital fulfills this request
- ☐ Other ______________________________