

I understand that once Frankford Hospital discloses my health information to the recipient, Frankford Hospital cannot guarantee that the recipient will not redisclose 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 this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Health Information Management Department of Frankford Hospital. The revocation will be effective immediately upon Frankford Hospital's receipt of my written notice, except that the revocation will not have any effect on action already taken by Frankford Hospital in reliance to this Authorization before it received my written notice of revocation.

I may direct my questions to the Health Information Management Department Correspondence Secretary. There is a Correspondence Secretary at each campus. They can be contacted during regular working hours Monday through Friday. Their addresses are:

Frankford Campus: Frankford Ave. and Wakeling St., Phila. PA, 19124
Torresdale Campus: Knights and Red Lion Roads, Phila., PA 19114
Bucks County Campus: 380 Oxford Valley Rd., Langhorne, PA 19047

Signature

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 the use or disclosure of my protected health information in the manner described above.

Signature of the patient

Date of Authorization

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

Signature of parent guardian or legal Representative

Relationship to the patient

Date

Revised: 3/94
12/02
4/03