

HAHNEMANN UNIVERSITY HOSPITAL
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Home Address: _____
Home Phone: _____ Other Phone: _____
Date of Birth: _____ Social Security #: _____
Date of Request: _____

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:

- Alcohol or Drug Abuse _____ (patient signature)
- Mental Illness _____ (patient signature)
- Developmental Disability _____ (patient signature)
- Psychotherapy Notes _____ (patient signature)
- HIV/AIDS Testing or Treatment _____ (patient signature)
- Sexual Assault _____ (patient signature)
- Genetic Testing _____ (patient signature)

RECIPIENT: _____

(Name of person or class of persons to whom Hahnemann University 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 Tenet fulfills this request
- Until the following event occurs _____
- Other _____

PURPOSE: I authorize Hahnemann University Hospital to use or disclose my health information (including the