HAHNEMANN UNIVERSITY HOSPITAL

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:______________________________ **DOB:**____________

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: ______________________________ ______________________________

I understand that once Hahnemann University Hospital discloses my health information to the recipient, Hahnemann University 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 Hahnemann University Hospital may, directly or indirectly, receive remuneration from a third party in connection with the use or 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 Hahnemann University Hospital; except, however, if my treatment at Hahnemann University Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Hahnemann University Hospital may refuse to treat me if I do not sign this Authorization.

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 Hahnemann University Hospital's Privacy Office at the address listed below. The revocation will be effective immediately upon Hahnemann University Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Hahnemann University Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact Hahnemann University Hospital's Privacy Office at Hahnemann University Hospital, Broad and Vine Street, Mail Stop 604, Philadelphia, Pennsylvania 19102 (phone # 215-762-4659, fax # 215-762-3303)

<u>If information relating to HIV/AIDS is released</u>, the following statement is relevant: "This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose."

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 Hahnemann University 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 Date

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Description of Authority (Relationship to Patient)