



**UNIVERSITY OF
PENNSYLVANIA
HEALTH SYSTEM**

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION -
NOT FOR USE IN CONNECTION WITH RESEARCH ACTIVITIES**

I hereby authorize the disclosure of my individually-identifiable health information as described below. I understand that this authorization is voluntary, and that if the organization authorized to receive this information is not a health plan or healthcare provider, the release of such information may no longer be protected by federal privacy regulations. I also understand that once this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s), and may no longer be protected by federal privacy regulations.

ALL ITEMS MUST BE COMPLETED

Patient Information:

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Last 4 digits of Soc. Sec. #: _____

Person(s) or class of persons authorized to disclose the information:

Person(s) or class of persons authorized to receive the information:

Description of the information that may be disclosed: *(please state clearly)*

The information will be disclosed for the following purpose(s):

The patient (or the patient's personal representative, if applicable) must read and initial the following:

- | |
|---|
| <p>1. I understand that this authorization will expire on ___/___/___ or upon _____ Initials _____</p> <p>2. I understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on this authorization. Initials _____</p> |
|---|

I understand that my refusal to sign this authorization form will not affect my ability to receive treatment or eligibility for benefits.

 Signature of Patient or Patient's Personal Representative (as applicable)

 Date

 Name of Patient's Personal Representative (as applicable)

 Relationship to Patient or Statement of Authority to act on Patient's Behalf (e.g. spouse, parent, legal guardian, person acting *in loco parentis*, etc.)