St. Christopher's Hospital for Children

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Last First Middle
Home Address:	
Home Telephone:	
Date of Birth:	

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:

- ☐ Mental Illness _____
- ☐ Developmental Disability _____
- ☐ Psychotherapy Notes _____
- ☐ HIV/AIDS Testing or Treatment (regardless of result) _____
- ☐ Venereal Disease _____
- ☐ Abuse of an Adult with a Disability _____
- ☐ Sexual Assault _____
- ☐ Child Abuse or Neglect _____
- ☐ Genetic Testing _____
- ☐ Other _____

RECIPIENT: **Name of person or class of persons to whom St. Christopher's Hospital for Children 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 Covered Entity fulfills this request.
- ☐ Until the following event occurs _____
- ☐ Other _____

PURPOSE: I authorize St. Christopher's Hospital for Children to use or disclose my health information (including the 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 St. Christopher's Hospital for Children discloses my health information to the recipient, St. Christopher's Hospital for Children 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.