Partners In Family Health, P.C.

Authorization To Use or Disclose Protected Health Information

COMPLETE THIS FORM AND SEND TO YOUR PREVIOUS DOCTOR IF TRANSFERRING INTO OUR OFFICE

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name:	**Date of birth:**	**SS#:**
Address (street, city, state, zip code):		**Telephone #:**

I hereby authorize Partners In Family Health, PC 1550 RODNEY ROAD to
PHONE (717) 846-8791 FAX (717) 718-8189
Receive from or Disclose to

NAME OF PHYSICIAN OR ORGANIZATION

ADDRESS:

DATES OF SERVICE :	**PURPOSE OF REQUEST:** __ Legal ___Moving out of Area __Insurance __ Specialist __ Transfer of Care ___Other_____

The following information is to be disclosed : (Please check one box for each item.)

Yes	**No**		**Yes**	**No**	
		Physician notes			Cardiac Studies
		Lab results			Consults
		Imaging reports			Immunization history
		Medicine history			Other:_____
		Complete medical history			

Sensitive Information:

The following information is protected by state and federal law. If any of this information applies to you, please indicate any or all information you would like released.

Alcohol or Drug Abuse Records **HIV Treatment**
Psychiatric Treatment Records **DOES NOT APPLY**

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:
(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatement. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

Signature of patient or legal representative:	Date:

If signed by legal representative, relationship to patient:

MAIL ANY RECORD OVER 10 PAGES, PLEASE DO NOT FAX!!!