Plumsteadville Family Practice
5612 Easton Rd PO Box 866 Plumsteadville, PA 18949-0866
Phone (215) 766-8844 Fax (215) 766-0733

Authorization for Release of Health Information

Patient Name: ___________________________________Date of Birth: ____________________
Address: ____
Phone Number: ______________________

_____ Release my health records to: OR _____Obtain my health records from:

Name/ Facility: ____Attn: ____________________
Address: ____
City: ______________________ State: _______ Zip: _________
Phone Number: ______________________________ Fax Number: ________________________

I understand:

a. My Medical record may contain information of a sensitive or extremely private nature, including, but not limited to a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high-risk behavior, hospitalizations, surgeries and any other medical or psychological disorder for which I may have been treated.
b. I or my representative may revoke or modify this authorization at any time by writing to Plumsteadville Family Practice except to the extent that information has already been disclosed. If information has already been in reliance on this authorization, revoking will only prevent future disclosure.
c. Plumsteadville Family Practice will not condition treatment, payment, enrollment or eligibility on the provisions of this authorization.
d. Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
e. I understand that I cannot be compelled to authorize release of any of my medical records.

__________________________________ __________________________________
Signature Date

____
Print Name

____
Relationship to patient and authority to sign (i.e. legal guardian, Power of Attorney)

THIS FORM IS TO BE KEPT AS A PART OF THE PATIENT PERMANENT RECORD

Photo ID Type and # __________________ Release by Employee: _______________________________