Chalfont Family Practice
65 E. Butler Avenue
Suite 201
New Britain, PA 18901
P: 215-822-3113 F: 215-822-0889

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S FULL NAME _____ PATIENT SS# _____

PATIENT'S MAILING ADDRESS _____ PATIENT'S DATE OF BIRTH _____

CITY, STATE, ZIP CODE _____ PATIENT'S TELEPHONE # _____

1. **I hereby authorize use of disclosure of protected health information:**

FROM:

_____
PRACTICE NAME/ORGANIZATION NAME

_____
STREET ADDRESS CITY STATE ZIP

TO:

Chalfont Family Practice
65 East Butler Ave
Suite 201
New Britain, PA 18901

2. The purpose for which disclosure is authorized: (Check where applicable)
_____ Medical Care _____Insurance Other: _____

3. I request that the following health information be included:
____Complete Medical Record ____History and Physical Exams ____Imaging Reports
____Immunizations ____Laboratory Results ____Pathology Reports
____Other : (Please Specify) _____

4. I understand that my medical record may contain information related to alcohol/drug abuse, mental health/rehabilitation and HIV/AIDS. This information will be disclosed unless I specify that the information is ***NOT*** to be disclosed by ***INITIALING*** below:
____Alcohol/Drug Abuse Treatment ____Mental Health ____HIV/AIDS

5. Covering the period of health care from _____to_____
6. I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. This authorization expires as of: _____ OR ____ This authorization has NO expiration due.
8. I understand that my treatment, payment, enrolment or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuance to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read and understand this authorization and authorize the use or disclosure of the covered health information as describe in the authorization.

_____ _____ _____
Signature of Patient or Personal Rep (Auth by Law) Date Relationship to Patient if signed by representative