Green and Seidner
Family Practice Associates, P.C.

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSE OF PROTECTED HEALTH INFORMATION

Please Provide Your Demographic Information (Please Print)
Patient Name: _____DOB: ____/____/____ SSN: _____-_____-_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

INFORMATION TO BE RELEASED TO:
Name: _____ Date _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

INFORMATION FROM:
Name: _____ Date _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Please stipulate what protected information shall be disclosed:

- ☐ Demographic
- ☐ Pharmacy/Prescription Records
- ☐ History/Physical Summary
- ☐ Emergency Department/Discharge Summary
  - *Date (s) of Admission/Discharge* _____
- ☐ X-Ray/Radiology Records
- ☐ Laboratory/Pathology Records
- ☐ Surgery/Operative Report
- ☐ Other Diagnostic Test/EKG, EEG, Scans ect… _____
- ☐ All Records, excluding HIV status, substance abuse, mental illness/counseling
- ☐ All Records, including HIV status, substance abuse, mental illness/counseling
- ☐ All Records, except _____

Information being disclosed from records whose confidentiality is protected by Federal Law{42CFR Part II(Confidential Alcohol and Drug Abuse Patient Information, 42C.F.R. Part II} **and Pa State Statues** {Title 55 P.W. **5100.32 and 5100.34** (a)&(b) **and DACCA, 71 P.S. 1690.108** (b)&(c) (PA Mental Health Procedure Act) (Confidential of HIV-Related Information Act, PA Law Act 148)

AUTHORIZATION AND SIGNATURE

I understand that I do not have to sign this form in order to receive treatment at Green Seidner Family Practice Associates, Even though the consent for release of information is valid for one year. I understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has taken in reliance thereon and that this consent will remain in force in order to effectuate the purposes for which it is given.

I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected healthcare information and there are no claim or orders pending or in affect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Date: _____/_____/_____

- ☐ Wish for this authorization to expire in 1-year from date of signature
- ☐ Wish for this authorization to expiree before one year: Expiry: _____/_____/_____

PATIENT SIGNATURE: _____

SIGNATURE OF PARENT/ LEGAL GUARDIAN
AUTHORIZED REPRESENTATIVE: _____ Witness: _____
Describe relationship of signee, if not patient: _____

- ☐ Unable to sign because: _____ Witness: _____

For Office Use Only:
Received: _____ _____ ID Confirmed: _____ _____ Completed: _____ _____
Initial Date Initial Date Initial Date