Authorization to Disclose Individually Identifiable Health Information,
Including Protected Health Information and Confidential HIV-Related Information

.

Patient Name _____ **DOB**: _____

Address:_____

_____ **SSN:** _____

I authorize: **James C. Wasson, MD**
534 S. Main Street, Nazareth, PA 18064
Phone: 610-746-1860

(Name and address of health care provider, health plan or health care clearing house)

To release to: _____

_____

_____

For the purpose of: All medical records generated by
_____**unless otherwise specified**

_____

HIPAA Release Authority. I authorize all health care providers or other covered entities to disclose information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules , **including** confidential information concerning: **Chemical Dependency Diagnosis/Treatment, Mental Health Diagnosis/Treatment including Psychiatric and Psychological Evaluation and HIV/AIDS Diagnosis/Treatment.** Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.
HIV is the virus that causes or indicates AIDS or HIV infection.

HIV-related information is information which concerns whether a person has been tested for HIV or has AIDS or an HIV-related illness, or could reasonably identify the person as having one or more of these conditions or has AIDS or an HIV-related illness, or could reasonably identify the person as having one ore more of these conditions.

Dates of Service: Three years prior from last date seen. Anything prior than 3 years there will be a charge for copying plus postage. Copying charges are listed on the reverse side of this form.

The type of information to be disclosed is as follows: **All Medical Records** **Lab Reports**
Consultation Reports **Discharge Summaries**
Mental Health Evaluations _____
(Other)

- I understand that I may revoke this Authorization at any time as long as I do so in writing. My revocation will not apply to any disclosure of my medical information prior to the revocation and based on the original Authorization. I also understand that I have the right to inspect the material that is to be released. This Authorization must be signed and dated.
- I understand that generally the person(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.
- I have read and understand the above statements as they apply to me. I authorize the release/disclosure of information for the purpose(s) stated above.

Patient signature: _____ Date: _____

Witness of Signature: _____ Date: _____

NOTICE OF PROHIBITION

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY PENNSYLVANIA LAW. PENNSYLVANIA LAW PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR IF AUTHORIZED BY THE CONFIDENTIALITY OF HIV-RELATED INFORMATION ACT, P.S. SECTION 7601, *ET. SEQ.,* THE MENTAL HEALTH PROCEDURES ACT, 50 P.S. SECTION 7101, *ET. SEQ.* AND THE DRUG AND ALCOHOL ABUSE ACT, 71 P.S. SECTION 1690.101.